DOCUMENT RESUME

ED 409 502 CG 027 749

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TITLE	Implementing Welfare Reform: Solutions to the Substance Abuse Problem.
INSTITUTION	Children and Family Futures, Irvine, CA.; Drug Strategies, Washington, DC.
SPONS AGENCY	Annie E. Casey Foundation, Baltimore, MD.
PUB DATE	97
NOTE	66p.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Drug Abuse; *Drug Addiction; Government Role; *Illegal Drug Use; *Rehabilitation Programs; State Programs; State Regulation; *Substance Abuse; *Welfare Recipients; *Welfare Services
IDENTIFIERS	Treatment Verification; *Welfare Reform

ABSTRACT

Implementing welfare reform will require difficult decisions from states about how to treat welfare clients who have problems with alcohol or other drugs (AOD). The processes by which states may respond to welfare reform are detailed in this guidebook. It is suggested that states begin with values clarification regarding welfare clients who abuse alcohol or other drugs. In recognition of both the realities of addiction and the demands of community opinion, state policy must balance the responsibility of public and private agencies to provide effective treatment with the reciprocal responsibilities of clients to comply with treatment requirements. Steps that states must take to respond to AOD problems are outlined. They include the following: clarifying values; determining the extent of AOD problems and the need for AOD services; making decisions on screening, assessment, and testing practices; determining treatment options; defining job readiness; addressing the needs of children; making decisions regarding felony drug offenders; working with other needed services; and measuring outcomes of a state's response to welfare reform. Some states' experiences and some program models are detailed here. Six appendices give information on legal requirements, estimates of welfare clients with AOD-related problems, screening and assessment issues, drug testing, patient placement, and factors affecting treatment outcomes. (RJM)

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Sweeping Welfare Overhaul

Implementing Welfare Reform:
Solutions to the Substance Abuse Problem

CG027749

Welfare Shifted To States

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This Guidebook was made possible by a grant from the Annie E. Casey Foundation

The Guidebook was written by Nancy K. Young, Ph.D. and Sidney L. Gardner, M.P.A. of Children and Family Futures with the Editorial and Publication Assistance of Drug Strategies

Children and Family Futures

Children and Family Futures is dedicated to improving outcomes for children and families, particularly those affected by alcohol and other drugs, by providing technical assistance and training to government, community-based organizations, and schools on strategic planning, evaluation, and measures of effectiveness.

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Executive Summary

Implementing welfare reform will require difficult decisions from states about how to treat welfare clients who have problems with alcohol or other drugs (AOD). States' recent experiences offer clear lessons: providing treatment for AOD problems is a necessary step toward job readiness. Not every welfare recipient will succeed, either in work or in treatment. But success rates can be improved substantially if states use what is known about what works.

This guidebook details the process of planning states' responses to welfare reform, which should begin with clarifying values regarding welfare clients who abuse alcohol or other drugs. In recognition of both the realities of addiction and the demands of community opinion, state policy must balance the responsibility of public and private agencies to provide effective treatment with the reciprocal responsibilities of clients to comply with treatment requirements.

This document also describes important steps that states must take to respond to AOD problems among welfare recipients. The steps are outlined below:

- **Frame and clarify the value judgments that must be made in setting priorities.**
  Define the responsibilities of welfare recipients and the responsibilities of society to help them.
- **Determine the best available estimates of the AOD-affected population.**
  Using methods proposed, estimate the extent of AOD problems among the welfare population.
- **Make decisions on screening, assessment, and testing practices to be used.**
  Decide which screening, assessment, and testing tools will best determine the services AOD-using clients should receive, clients' motivations, and the status of parents' job readiness and parenting.
- **Make decisions about treatment options.**
  Review the currently available treatment options for recipients of TANF and assess how those treatment options can most effectively respond to the needs of these clients.
- **Allocate available funds from TANF and other sources to treatment services.**
  Develop estimates of treatment costs for TANF clients, the adequacy of Medicaid benefits for AOD treatment, and cost offsets of treatment for other agencies. Estimate the short-term costs of serving AOD-abusing clients against the cost shifting effects of not providing treatment to these clients.
- **Define "job readiness" for AOD-using clients.**
  Prepare clear definitions of the extent to which participation in AOD services can be defined as job readiness activities, based on clients' ability to work and engage in treatment at the same time.
- **Address the needs of children of welfare recipients with AOD problems.**
  Since children are affected both by their parents' substance abuse and by the sanctions that may be imposed if parents do not comply with time limits or treatment and work requirements, welfare reform planning should review the potential impact of TANF requirements upon these children.
- **Make decisions regarding felony drug offenders.**
  Establish the actual number of felony offenders in the welfare population, and determine whether the state will uniformly exclude them or develop conditional support tied to treatment.
- **Establish linkages with other needed services.**
  Based upon the needs of AOD-using clients, determine which agencies should be the major partners of the TANF and AOD agencies, the mix of delivery systems to be used in delivering services, and the appropriate roles for religious, community-based, and for-profit organizations.
- **Establish the program-level and community-level outcomes to measure progress.**
  Decide what outcomes are the best measures of program effectiveness. Determine what process the community has begun to set community-wide benchmarks as standards.

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I. The Need for a State Response to Alcohol and Other Drug Problems among Parents on Welfare

States face many complex issues in preparing to implement the new federal welfare reform. This guidebook focuses on one of these: *how to respond to the use and abuse of alcohol and other drugs (AOD) among the parents in the welfare population.*

The importance of addressing this issue is based on three realities:

- A significant number of welfare recipients use alcohol and other drugs in ways that impair their ability to secure and keep jobs, as well as their ability to be effective parents. The estimates of this population range from almost 5% to 39% of welfare recipients.[1] Many of these AOD-using clients are parents with children who experience the intergenerational effects of their parents' AOD abuse. Implementing welfare reform presents an opportunity for state and local government to help ensure that the needs of the children of AOD-using parents are met.

- The AOD-using[2] population is unlikely to succeed in welfare-to-work transitions without effective treatment services. This would affect a state's overall rates of job placement and welfare exit significantly enough to undermine its efforts to carry out welfare reform. In a 1995 study by the Legal Action Center, 99% of state and local welfare directors said alcohol and drug treatment services were either "extremely important" or were "somewhat important" in assisting welfare recipients to get off welfare.[3]

- States' interpretations and implementation of the new law (P.L. 104-193) will impact AOD-using parents. Relevant provisions include time limitations for receiving welfare benefits, the prohibition from providing benefits to persons convicted of drug felonies, the option for drug testing, and the definitions of job readiness activities (Appendix 1 discusses these provisions).

This guidebook explains the provisions that will affect persons with AOD problems who will be covered under the new Temporary Assistance for Needy Families (TANF) program (this document does not specifically address the SSI or GA populations), suggests steps for planning state responses to these clients' needs, and describes state and community policies and programs that effectively address these needs.

Rationale for Targeting AOD-using Recipients as a Priority

Data indicate that long-term welfare recipients are more likely to have AOD-related problems than short-term welfare recipients. The Urban Institute examined the National Longitudinal Survey of Youth (NLSY) to ascertain if there were barriers to employment among the welfare population.[4] It found that the indicators of substance abuse varied by the length of time that women had received welfare. While only 13.6% of women on welfare less than 24 months showed some physical signs

of problem drinking (shakes, loss of memory, drinking in the morning), 21.6% of women on welfare longer than five years showed those physical signs. Further, women on welfare between two and five years had higher rates of cocaine or marijuana use than did women on welfare less than two years. This higher rate of substance abuse problems among longer term, younger welfare recipients has also been shown in Utah, which has operated its welfare waiver since 1992.[5]

It is clear that ignoring welfare clients who abuse or are dependent on alcohol and other drugs will result in many of these persons showing up in other caseloads. The arrest and corrections data of the federal[6] and state[7] governments have repeatedly demonstrated significant cost offsets in criminal justice as a result of effective treatment. Research has also shown that treatment can reduce health, unemployment, child abuse, and other social system costs. These data strongly suggest that in the absence of treatment and deprived of public assistance these clients will end up in these other systems.

There are several essential elements of the rationale for priority attention to AOD-abusers in welfare reform:

Elements of the Rationale for Prioritizing AOD-using Clients

- Ignoring substance abuse problems will result in fewer job placements and successful welfare exits than the state needs in order to avoid federal penalties.
- Serving substance abusers will have cost-offsetting effects much greater than the initial costs or their proportionate numbers.
- This public health disease, if untreated, is unmistakably multi-generational in its impact. Without successful intervention, the children in these families are especially likely to return to the public systems as hard-to-serve clients in later years.
- With treatment of their parents, however, and family support that recognizes the needs of AOD-involved families, the potential for later costs of these children can be greatly reduced.
- Clients who are willing and able to participate actively in their own treatment deserve help as much as other clients with treatable diseases. Whether or not AOD-using clients are able to participate in treatment, their children should be given the opportunity to live a drug-free life in a family that cares for them.
- Existing AOD treatment services will allow a significant number of these clients to become successful workers, parents, and citizens.
- Time limits in the new legislation will have two effects: they will increase the urgency of dealing with AOD-related job impairments and they raise the possibility of ending assistance.

II. Preparing the State Response: The Critical Decisions

This report discusses two preliminary steps and eight elements of decision-making that should make up a state's preparation for responding to the AOD-using welfare population. These include:

Preliminary Steps

1. **Frame and clarify the choices about values that must be made in setting priorities.**
   As discussed in the prior section, decisions must be made as to whether welfare clients with AOD problems will be treated any differently than other welfare clients. Define the responsibilities of clients and the responsibilities of society to help clients who try to help themselves.

2. **Determine the extent of problems and needs among the AOD-affected population.**
   Using methods proposed in this document, estimate the extent of AOD problems and the related information needed to decide on which clients to target first.

Planning Elements

1. **Make decisions on screening, assessment, and testing practices to be used.**
   Review available screening and assessment tools and decide which will best help determine what kind of services AOD-using clients should receive, how well-motivated clients are, and the status of parents' job readiness, recovery, and family functioning. Place decisions about drug testing in the context of the larger screening and assessment system.

2. **Make decisions about treatment options.**
   Review the currently available treatment options for welfare clients and the number of clients who can be enrolled. Determine how those treatment options can be exercised to most effectively respond to the needs of those recipients.

3. **Allocate available funds from TANF and other sources to treatment services.**
   Based upon the choices about values and the estimates of AOD use among the welfare population, develop estimates of current cost figures for these clients. Derive available funding for treatment programs from these sources. Determine whether changes should be made in current definitions of Medicaid benefits for AOD treatment of welfare clients and how managed care organizations with Medicaid-covered clients should serve this group. Estimate likely cost offsets of treatment that benefit other agencies as a basis for determining the non-TANF share of treatment costs. Weigh the short-term cost effects of serving AOD-using clients against their long-term effects in offsetting future costs in welfare and non-welfare agencies. Collect state-of-the-art information on cost offsets in other systems (such as those developed in Oregon and other states as described in Section III).

4. **Define "job readiness" and prepare supportive services for clients with AOD problems.**
   Prepare clear definitions of the extent to which participation in AOD services can be defined as job readiness activities. Establish the manner of assessing clients' fulfillment of job readiness criteria consistent with the new law and time limits.

5. **Determine how children of TANF clients with AOD problems should be treated.**
   Because children are affected both by their parents' substance abuse and by the sanctions that may be imposed if parents do not comply with time limits or treatment and work requirements, welfare reform planning should review the potential impact of TANF services upon children of recipients.

6. **Make decisions about felony drug offenders.**
   Establish the actual number of drug felony offenders in the TANF population, and determine whether the state will consider them as a uniformly excluded group or develop treatment participation requirements aimed at this special population.

7. **Establish linkages with other needed services.**
   Based upon the best available information about the overlap of AOD-using clients in other agencies' caseloads, determine which agencies should be the major partners of the TANF and AOD agencies, from among child welfare, early childhood development, family support, Medicaid, mental health, domestic violence, law enforcement, and job training. Determine the mix of delivery systems to be used in delivering treatment and family support services to TANF clients with AOD problems. Consider ways to increase the capacity of current providers to provide effective, accountable services. Assess the possibility that the new openings for religious, community-based, and for-profit organizations may provide an expanded opportunity to energize and improve the delivery system.

8. **Establish the program- and community-level outcome measures to assess progress.**
   Choose the outcomes that are the best measures of program effectiveness, both at the level of programs and across the community. Involve front-line workers, clients, and community stakeholders in choosing the indicators that will best measure progress in welfare reform.

Preliminary Step 1: It Starts with Values

The question of how to treat welfare clients who use alcohol and other drugs emerges from centuries of social policy history, including the temperance movement, Prohibition, Elizabethan poor laws, and the Protestant work ethic. The underlying values that are at the foundation of these policy debates are not issues discovered in the 1990s; how to treat the unemployed and the substance abuser are questions that have been with us since the 17th century.

David Ellwood, of the John F. Kennedy School of Government at Harvard, and other veterans of earlier versions of welfare reform argue that a basic consensus on values is the starting point for a serious discussion of welfare reform. Too often we have not been clear about the values that

underlie slogans like "end welfare as we know it" and "make work pay."[8] Moreover, in dealing with AOD-using welfare recipients, two sets of deeply held attitudes come into play: those toward welfare recipients and those toward addicted persons. As Mark Greenberg, from the Center on Law and Social Policy, has noted, the values of "work, family, and responsibility" are inherent in the welfare debate. When AOD use is also present, these value judgments are intensified because of our society's strong attitudes toward substance abuse.[9] The welfare parent who is a substance abuser is often stereotyped as shiftless, neglectful of family, and irresponsible.

Nearly everybody has an opinion about addiction; after all, half of all Americans know someone who is addicted to alcohol or other drugs.[10] We tend to moralize about addiction, especially for parents who are responsible for children. Having condemned those who abuse alcohol and other drugs, it is not difficult to move from that condemnation to an instinctive agreement with policy that holds the individual completely responsible for stopping this behavior: if addicts don't stop the abuse of drugs or alcohol, they should lose their welfare benefits and then their children.

Addiction involves not only will power, but also changes in brain chemistry and genetic predisposition. It is all of these—and it is the combination that makes it a more complicated subject than our basic instincts tell us.

But addiction involves not only will power, but also changes in brain chemistry and genetic predisposition. It is all of these—and it is the combination that makes it a more complicated subject than our basic instincts tell us. We need to be clear what value judgments we bring to this discussion, but we also need to understand the complex nature of addiction so our values are informed, rather than merely instinctive. These value judgments, then, are fundamental to our thinking about addiction and welfare.

The debate on values—about how to treat AOD users who are on welfare—has been avoided for the most part in the national discussion of welfare reform, with the notable exception of the brief debate over the Gramm amendment (Section 115, which discusses felony offenders). But the vaiues part of these issues is inescapable. With capped funding from the federal government, resource constraints and time limits force value choices: which clients should be helped to get the services they need to exit welfare and become self-sufficient working families? A debate that focuses solely on past offenders says little about how we view the far larger group of parents who may or may not be trying to escape their dependence on both welfare and AOD.

So values matter to the larger society, and personal responsibility has become a theme with direct relevance to addiction among welfare clients. Moreover, we should not overlook the fact that of the ten major waiver requests made by states during the years prior to the passage of federal welfare reform, at least five were "personal behavior waivers" which sought to require changes in behavior of welfare clients, in their work, their education, or the size of their families.[11]

The consensus is clearly expressed in the new law: aid to welfare clients must be work-based, unless clients have some impairment or responsibility for children with special needs that prevents

work. Yet that consensus does not address whether or not policymakers perceive AOD dependence to be an impairment for which the client is fully responsible, or a condition for which society shares a responsibility to help abusers treat their condition so they can work. Neither position raises the further issue of the cost effectiveness of treatment; at this level the discussion is about personal and societal responsibility.

A debate that focuses solely on past offenders says little about how we view the far larger group of parents who may or may not be trying to escape their dependence on both welfare and AOD.

Other elements of the values debate include the notion of a "second chance"and whether AOD-using offenders deserve a second chance. The issue is what demonstration of a client's intentions to change behavior is needed for society to judge that offenders deserve support in their efforts to escape poverty and addiction.

To frame the choices about values, three questions could be asked:

- Do we believe that welfare recipients with a substance abuse problem deserve any help to overcome their AOD problems, or should they be treated like all other welfare clients?
- What is the community's responsibility to AOD-using welfare recipients if they are willing to make an effort to overcome their dependence by complying with treatment requirements?
- Do AOD-using clients deserve a second chance if they do not comply with initial treatment requirements?

These are not technical issues or budget issues, but value judgments. Debating them as such will raise the level of the discussion and avoid the pretense that values do not matter.

A Centrist Position on Personal Responsibility

A centrist position on the value choices acknowledges both the personal responsibility of AOD users and the institutional responsibility of welfare and treatment agencies to help these clients. It is significant that the welfare reform legislation was originally labeled the Personal Responsibility Act. Now, as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), the dimension of personal responsibility must be taken seriously. However, it would accomplish little to ignore the fundamental nature of addiction as a disorder in which brain chemistry, genetics, and personal behavior all matter. As the director of the National Institute on Drug Abuse said:

> We now know that drug abuse is a chronic, relapsing medical disorder that is measurable, preventable, and treatable.[12]

The issue of *mandated treatment* also comes into play. There is substantial evidence, demonstrated in the treatment outcomes of criminal justice populations, that coerced treatment can be effective in helping some clients control their addiction.[13] Other research has shown that women mandated to treatment after the birth of a drug-exposed baby reduced their drug use as much as women who voluntarily participated in treatment.[14] In a workplace-based study, employees who were coerced to participate in treatment after testing positive had less severe problems initially than clients who volunteered for treatment; the coerced group were more likely to stay in treatment and achieved substantial reductions in their AOD-related problems. Their levels of improvement were comparable to the volunteer clients.[15] The provisions of the welfare legislation that represent mandates for treatment can, *if combined with the resources and support to make the mandates effective*, call upon clients to demonstrate a change in their behavior and promote personal responsibility in ways that respond directly to the offer of treatment and the mandate for treatment.

Preliminary Step 2: Determine the Extent of AOD Problems and Needs for AOD Services

The research literature and states' practical experience with AOD users among welfare recipients make an important distinction between the *prevalence* of AOD use and the more serious issue of *impairment* as a result of use.[16] Measures of AOD use or its prevalence or frequency do not indicate the degree of impairment resulting from use. In the AOD field, widely used diagnostic criteria recognize differences between use, abuse, and dependence. What is most relevant in welfare-to-work programs are the criteria for both substance abuse and dependence which emphasize problems in fulfilling occupational roles.

Estimates of the Percentage of Welfare Clients with AOD Problems

Four major studies have been conducted to estimate the percentage of welfare clients in the nation who have AOD-related problems. In these samples, which are representative of the household population, and in state-level studies, estimates of the portion of the welfare population affected by substance abuse range from 15.5% to 39.2%. The wide variance in the estimates results in part from different methods in obtaining the sample population and the age group included. Of equal importance, different thresholds of AOD use and related problems were used as the criteria for defining the welfare population in need of AOD services. The details of these studies and the different methodologies used in each are described in Appendix 2.

Estimates of the portion of the welfare population affected by substance abuse range from 15.5% to 39.2%. The variation results from different sampling methods, age groups, and from applying different thresholds of AOD use and problems as criteria for defining service need.

An important distinction needs to be made between *the percentage of all welfare recipients* with AOD problems and *the percentage of those remaining after initial job placements are made*. State officials have stated that the percentage of AOD problems among those clients who are harder to place is much higher, and that the percentage will rise after the initial placements under the two-year

time limits. As the 1996 Congressional Budget Office report on work requirements said, "...states may succeed in reducing their caseloads...[but] the requirements would still be difficult to meet because the remaining caseload would likely consist of individuals who would be the most difficult and expensive to train."[17]

Based on states' data and on extensive discussions over the past year in national and statewide forums, a consensus estimate of AOD-affected welfare clients emerges among practitioners, converging on at least 25%. The federal estimates were lower: federal officials analyzing impairment from substance abuse in the AFDC population felt that *both* a "seriously impaired" group (4.9%) and a "somewhat impaired" group (10.6%) needed treatment services. These statistics, it should be remembered, have human faces: the range of federal and state estimates represents between 600,000 and 1 million mothers on welfare and needing AOD services.

These statistics, it should be remembered, have human faces: the range of estimates represents between 600,000 and 1 million mothers on welfare needing AOD services.

Yet since 1991, annual admissions for women to the publicly funded treatment system have averaged approximately 500,000 per year and approximately 10% were receiving AFDC.[18] Furthermore, as of July 1996, there were over 63,000 people who had already asked for help with their substance abuse problem, and had been assigned to a waiting list for a treatment slot.[19] Recognizing the number of mothers on welfare needing services—600,000 to 1 million women—makes clear that treatment will not be readily accessible in all states.

Equating drugs and alcohol with poverty and welfare is a mistake. A recent poll reported that nearly half of all Americans (45%) say they, someone in their family, or a close friend uses illegal drugs; more than half of those who reported knowing someone with a "moderate or serious" drug problem lived in households with incomes of $35,000 or more.[20] Analysis of the National Household Survey on Drug Abuse found that nearly 75% of parents who reported illicit drug use in the past month had incomes above the poverty line, and more than 25% had incomes greater than three times above poverty.[21]

Given the stereotypes that prevail in *both* the welfare field and the AOD field, clarity is also essential about the impact of race and income on clients who need help from both systems to overcome their dependence upon both the welfare system and alcohol and other drugs. Wilson discusses the impact of drugs on the problem of the new urban poor, pointing out that a higher percentage of residents of two urban neighborhoods identified drug abuse as a problem than identified unemployment or crime in their neighborhoods.[22] Grant has reviewed the status of various sociodemographic correlates of drug use, finding that whites were *more likely* to use drugs than blacks or Hispanics, *were indistinguishable* from blacks and Hispanics in their probability of dependence, but were significantly less likely than blacks or Hispanics to persist in dependence.[23]

What this underscores is that welfare recipients may *start* using alcohol and other drugs at roughly the same rates as other persons, but their income, education and other factors result in their

persisting in use and abuse longer. This appears to be independent of race (with the exception of the impact of crack cocaine on African-Americans in the 1980s, which Wilson and others note is decreasing). Clearly, education and income are as closely related to welfare as they are to substance abuse.

Determining the Size of a State's AOD-using Welfare Population

A state should make a special effort to determine the size of its AOD-using population. Several methods are available, using a representative sample of a state's welfare clients. The best screening methods can differentiate between AOD use, abuse, and/or dependence to help in estimating the size of the population *that might be impaired* from obtaining or keeping a job due to their use. However, as discussed in the next section, drug testing alone using biologic methods (e.g., testing of urine, sweat, hair) will not tell how many welfare clients need AOD services to prepare them to become gainfully employed.

Steps toward Determining Prevalence of AOD-impairment among Welfare Recipients:

- Review the estimates that have been conducted either nationally or in other states and make a judgement as to the comparability with your state's clients. This may not result in reliable data for scientific standards but may be a necessary first step in ascertaining the size of the problem in early discussions.
- Add a limited number of questions to the welfare intake process, such as the questions in the CAGE (see Appendix 3 for details) in order to collect more information about signs and symptoms of AOD problems within your caseload (this will require training of intake workers to implement).
- Conduct a joint study using staff from the welfare and AOD departments with a representative client sample and a reliable screening tool such as the Substance Abuse Subtle Screening Inventory (SASSI; see Appendix 3). Using AOD-trained staff for a time limited study will provide the best estimate of the size of your AOD problem.
- Conduct a study based on clients' self-report of their use and related problems, include an AOD-trained clinician to provide a professional screening; and use a biologic method for confirmation. This method may provide the most reliable data but will also be the most costly to implement.

Planning Element 1: Screening, Assessment, and Testing

Screening, assessment, and testing are different ways of determining the condition of welfare recipients with respect to their AOD use, abuse, and dependence. The three processes are related, but have distinct purposes and provide different information. Prior to implementing any screening, assessment, or testing protocol, the goals of the method should be clarified.

Screening

The briefest of the three processes, screening determines the probability that an AOD-related problem exists with a specific client. Since one of the symptoms of AOD dependence is the client's denial of problems related to his/her use of alcohol or other drugs, asking the "right questions" and carefully interpreting the client's answers are required. The process includes a brief set of questions to distinguish quickly between those who are more or less likely to need further AOD evaluation. Screening is thus a preliminary step that measures whether critical features of the problem are present. A screening instrument should have a high degree of sensitivity (it should be broad in its ability to detect individuals with a potential AOD problem regardless of the specific substance being used). Examples of several commonly used screening instruments including the CAGE and the SASSI are described in Appendix 3. Options after screening should be limited to: (1) a more comprehensive assessment seems needed; (2) more assessment is not warranted at this time; or, (3) the screening will be repeated at a later time.[24]

***Screening** determines whether a client has an AOD problem;*
***Assessment** determines which aspects of the client's life are affected by AOD use, abuse, or dependence; and*
***Testing** determines if the metabolites of particular substances are present at specific levels at a single point in time.*

Assessment

An assessment is a process of collecting information to determine which aspects of the client's life are affected by AOD use, abuse, or dependence. The goal is to determine admission to an appropriate treatment program and to develop a treatment plan. The criteria for determining an adequate level of care are often based on the client's level of functioning across several domains, including physical, psychological, and social domains as well as the client's relapse potential (the criteria are explained more fully in this report's discussion of treatment). Assessment also involves an in-depth review of strengths as well as deficits to be addressed in the treatment program. In addition to treatment planning, the assessment data are used as baseline information for outcomes accountability. Areas of assessment include characteristics and variables related to alcohol use, other drug use, social and family relationships, psychological functioning, legal status, medical conditions, and employment/educational status. While several assessment instruments are in use, the Addiction Severity Index (ASI)[25] is the best known and most widely used instrument to assess clients' problems in each of these domains. Information on commonly used assessment instruments is included in Appendix 3.

Testing

The most common material used for drug toxicology screens is urine; however, drug use can be detected from a variety of sources including hair, blood, and sweat. Drug testing has two primary purposes: (1) to determine recent drug use in order to impose sanctions, and (2) to deter drug use

during early stages of treatment. There are philosophical differences between these different uses of drug testing. The literature on testing and the experiences of private companies and of states support the following consensus:

- Testing is a reality. It is used by three-fourths of American companies with more than 250 employees, and it is cited by the White House Office of National Drug Control Policy as a positive factor in prevention and treatment of drug use. The permissive language in the new welfare legislation makes it very likely that states will consider testing for both sanctioning and deterrence purposes.

- The drawbacks of testing—its cost, its invasiveness, its ineffectiveness with alcohol, and its tendencies toward false positives and under-detection—are important caveats. Of equal importance, however, is *making appropriate use of testing as one part of an overall treatment program including thorough assessment and follow-up*, rather than as a punitive mechanism operating out of context.

- The advantages of testing—its deterrent value, its ability to increase the motivation for some users to seek and sustain treatment, and its message to the public that recipients of assistance are being held to publicly accepted standards of behavior—outweigh its drawbacks, but only as long as testing is linked to evaluation and treatment.

The growing use of drug testing in the workplace is relevant when considering testing in welfare-to-work populations. Drug use among U.S. workers decreased from 19% in 1979 to 8.1% in 1993, and three out of four companies with more than 250 employees have formal antidrug programs and policies in place.[26] So an equitable approach to testing potential workers must consider how current employees are treated, since future workers should anticipate both pre-employment and on-the-job testing as normal parts of their workplace experience. While the cost-benefit of workplace testing procedures has recently been questioned,[27] businesses are convinced that they work, and they are commonplace in today's large companies. When a government entity is the testing authority, however, there are other issues of personal rights and privacy that are not the same as those in private-sector employment. These legal and constitutionality issues are not yet fully resolved.

Other legal implications of testing are significant. In the context of moving TANF recipients from welfare to work, both ethical and legal issues may be raised if licit drug abusers—alcohol abusers—are completely ignored in the testing protocols. One of the most important of these issues is the fact that under the Americans with Disabilities Act of 1990 (ADA), alcohol addiction, unlike drug addiction, is treated as a disability. Moreover, a self-declared former illegal drug user is also legally protected under the ADA, although a current drug user has no such rights.[28] The issues of search and seizure of biologic samples as violations of privacy are also certain to be raised in the context of drug testing of welfare recipients. Separate analyses of the legal issues of testing have been undertaken by the Legal Action Center and are available from their offices in New York and Washington.[29]

Large-scale testing programs can be expensive. One rough estimate for large-scale testing comes from the 1996 National Drug Control Strategy, which announced that $42 million had been requested to test "as many as 60,000 Federal suspects" arrested each year. This averages out to $700 per person.[30] A Los Angeles County agency representative reported that the 1996 budget of $300,000 to drug test parents in their child welfare system was expended within the first three months of the program. Their current budget estimates that $719,000 is required for 46,360 tests.[31] State representatives point out that costs rise as testing programs respond to the need to meet legal requirements, such as procedures to assure that a secure chain of custody exists for testing samples.

Again, as long as testing is used within the context of treatment and aftercare, it can be a very useful tool. A recent RAND report prepared for the National Institute of Justice found that the drug testing used to monitor compliance in drug treatment programs—whether voluntarily or mandated—reduced drug use among their study population.[32]

To summarize, to deter drug use and increase the employability of a welfare recipient, it is fiscally responsible to *screen* for indications of alcohol and other drug use through a brief questionnaire; *assess* for substance abuse or dependence and any related problems including employability; and to use *drug testing* as an adjunct to client assessment and treatment planning and monitoring. The critical determinant of the effectiveness of testing remains whether it is used alone or as part of a broader array of tools to respond to the needs of the client—and the client's desire for support in coping with his or her addiction. A more detailed explanation of testing procedures and methods, as well as a list of drugs and detection periods, is provided in Appendix 4 of this report.

Planning Element 2: Treatment Options

Many different kinds of treatment settings and methods exist. Mismatching clients with inappropriate treatment options can be very expensive, time-consuming, and ineffective. Three basic components are included in treatment—settings, programs, and therapeutic approaches. The AOD field often uses the term *modality* to refer to the mix of setting and program that are combined to "reduce symptoms or induce behavior change."[33]

The key points for state agencies considering treatment planning decisions are: (1) not every client in need of AOD services requires the same level of structure and intensity of services; and (2) if appropriate structure and services are provided to meet the needs of clients and their families, effective triage of clients to the appropriate level of care and services can result in significant cost savings to the state.

Treatment can be provided in different settings, including hospitals, residential care facilities, outpatient counseling centers, work places (i.e., Employee Assistance Programs), and, more recently, at schools. Each setting may operate more than one program, and programs often use more than one therapeutic approach. For example, in addition to residential-based treatment, a hospital may also provide intensive outpatient programs and detoxification services. The intensive outpatient program may employ therapeutic approaches using cognitive-behavioral therapy and self-help (e.g.,

Alcoholics Anonymous). Modality, then, is the combination of the setting (e.g., the hospital-based facility) and the program (e.g., intensive outpatient), which uses various therapeutic approaches (e.g., cognitive-behavioral therapy and self-help meetings).

AOD modalities vary in regard to the "intensity" of services delivered—the degree of structure or monitoring provided to the client. A therapeutic community with 24-hour supervision, for example, is a highly structured environment, while weekly outpatient groups are examples of less structured treatment programs. Treatment intensity and structure should be tailored to the needs of the individuals and families involved. As Kinney notes,

> ...matching clients to specific treatment modalities can be very cost effective. Not everyone needs 12 or 24 months in a treatment center. Some may not even need 14 days in detoxification or 9 months in outpatient treatment. Involvement in a 12-step program alone may be sufficient for a few clients after an inpatient detoxification or treatment center.[34]

Determining the Necessary Level of Care

Matching clients to the most appropriate treatment requires an assessment, which usually follows a screening to determine that a client has an AOD-related problem. There are three primary purposes to an AOD assessment: (1) ensuring that the client is placed in the appropriate level of care; (2) establishing a treatment plan; and (3) collecting baseline measures for monitoring the progress of a specific clients and for treatment outcome studies of all clients in the program.

There are obvious cost differences between care in a highly structured setting and less intensive outpatient care. The American Society of Addiction Medicine (ASAM) has developed criteria to assess which treatment options and level of intensity are appropriate for clients.[35] The dimensions assessed and the levels of services available to clients are listed in Appendix 5 of this report. Complete details, explanation, and training on implementing the criteria are available through ASAM (see information in the Endnotes). In addition to detoxification services, there are three levels of outpatient care and four levels of residential care. It is particularly important in discussions concerning the welfare population to be cognizant of the full range of treatment possibilities. This range of care allows some clients to participate in treatment services while they are also completing job training or working, while accommodating those who are more impaired with the more intensive levels of care.

The second part of assessment is developing a treatment plan that identifies the problems to be addressed and the services to be delivered during treatment. For example, if a client is experiencing marriage and family problems related to his/her drinking and/or other drug use, then the treatment plan should include family therapy to resolve those problems during treatment.

The specific therapeutic approaches are generally divided into three categories, with some adding a fourth: (1) physical methods, (2) psychological methods, (3) social methods, and (4) spiritual methods.[36, 37] The categories are described in the following table:

Physical Methods	Psychological Methods	Social Methods	Spiritual Methods
Detoxification Medications Acupuncture	Group, family, and individual psychotherapy Aversion therapy Behavior modification	Legal Strategies Rehabilitation Social skills training Self-help groups and mutual aid	Religiously oriented self-help groups

Women's Specialized Treatment Needs

In working with the welfare population, special consideration should be made for the treatment needs of women. Reviews of the literature on women's treatment issues often mention the following critical components of women's AOD treatment programs:

- Many women seeking treatment for AOD problems have been victims of physical and/or sexual abuse; these complex issues can often be triggers for relapse and most often need to be addressed in gender-specific programs by women treatment professionals.
- The three greatest barriers for women to seek and remain in treatment are: stigma, fear of losing custody of their children; and the lack of child care for their children while they are in treatment.
- Specialized services for women should include health and nutrition, intervention for domestic and community violence, intervention for children who may be affected by prenatal drug exposure, housing needs, parenting education and skill building, vocational training, and employment assistance.[38] A family focus in designing and implementing these programs is critical, and builds on lessons of many successful projects.[39]

Much of the existing treatment methodology was designed for middle-aged white male alcoholics or lower income male heroin users. Historically, AOD-related problems among women have rarely received the level of scrutiny directed at those among men.[40] With insufficient research on women's needs until recently, professionals believed that women experienced AOD problems in the same ways that men did. This belief that research findings from male subjects could be generalized to females has been termed the "Adam's Rib Syndrome."[41]

Ingredients of a Successful Program for Parents with AOD Problems

Kinney, Barth, Ingersoll, and others have suggested the following ingredients to assure better treatment outcomes in programs for parents affected by AOD problems, including:

- in-home care which is longer term and supervised more loosely than the intensive short-term family preservation services
- assembling "services packages" which enable parents to choose the elements they would accept
- shared family care including group homes
- worker training in strength-based assessment and treatment
- use of volunteers and kinship care to support parents in treatment.

Despite earlier neglect of the need for women's programs, longitudinal epidemiological studies have recently focused on women's drinking.[42] In addition, Congress acted in 1991 to ensure that funding for women's treatment programs increased in the states by mandating that states increase the funding from their federal block grant for women's services by 5% per year for the following three years.

However, women are still under-represented in publicly funded AOD treatment admissions. For the past several years, less than one-third of all admissions for both alcohol and drug treatment were for women, representing approximately 500,000 treatment admissions. Of those admissions, only a small percentage of women were treated in gender-specific specialized programs.

The problem for welfare agencies, when considering that the majority of the treatment system is focused on men, is that some of the beliefs about men's treatment clash with an emphasis upon women in treatment. Treatment programs for men tend to use confrontational tactics to break through denial mechanisms, which may be inappropriate for women with low self-esteem who tend to blame themselves for their problems and may also be past victims of violence. Programs that emphasize rehabilitation for addicted men with past work histories may be less relevant for women with far less educational or vocational skills and work history. Kinney and others have compiled extensive materials on the recommendations for program design drawn from the comprehensive programs for pregnant and parenting women.[43]

Given the specific references in the law to domestic violence and the substantial overlap between AOD use and domestic violence, planners should carefully review the extent to which these two problems affect an overlapping group of TANF-eligible clients. Both battered women and batterers are significantly affected by AOD use; several studies have found that over 40% of homeless lower income women report both physical abuse and AOD abuse.[44] In a study of domestic assault incidents in Tennessee, 94% of the assailants and 43% of the victims had used alcohol and/or other drugs in the six hours prior to the assault.[45]

A woman who successfully completes AOD treatment and gets referred to a job but returns home to a relationship marked by domestic violence has not eliminated the major obstacles to achieving success in work and parenting. And, in the words of a 1995 conference, children in such a situation are "twice at risk" children—exposed both to parental addiction and family violence.[46]

The welfare law recognizes these connections in encouraging states to screen, identify, and refer domestic violence victims and in providing an option for variations from time limits, residency requirements, and other provisions of the law to the extent that such requirements may make it more difficult for victims to escape domestic violence or may unfairly penalize them. Thus, for a victim of domestic violence in AOD treatment who is going through job interviews, training, and making child care arrangements that make it possible for her and her children to leave an abusive home, the language of the law could enable suspension of the time limits if the cause is reasonably linked to past or current likelihood of domestic violence (although DHHS decisions appear likely to require that such cases come under the 20% exemption, thus competing with other clients having other reasons for exemption from the time limits). Massachusetts and a few other states have forged

strong links between domestic violence agencies and child protection services agencies.[47] For some clients, these will be among the most important support services available.

Assessing Treatment Effectiveness

AOD treatment programs must be assessed by welfare and AOD agencies to determine their effectiveness with clients who have families and their impact on employment-related outcomes. The relative effectiveness of programs must be periodically reviewed both to ensure that clients are referred to programs with the best prospects for success and that scarce resources are directed to the best programs.

Critics of the current treatment system argue that very few clients achieve full recovery. Some of these criticisms, however, are based on studies of long-term, heavily addicted heroin and/or cocaine subgroups. In addition, some have argued that studies that have demonstrated cost offsets in other social systems (particulary criminal justice and health care) are methodologically flawed.[48] Despite these assertions, the President's Commission on Model State Drug Laws commissioned a review of the scientific literature on socioeconomic evaluations of addictions treatment. The evidence analyzed was from a variety of national studies conducted in both the publicly funded and the private-pay treatment systems over the past 20 years. The authors conclude that the benefits derived from treatment are convincing evidence that

> ...cost-offsets 'pay for' the cost of treatment within two to three years, are exceedingly durable, and are equally marked in female and male treatment populations.[49]

The authors note that benefits of alcohol treatment accrue to the health care system, while cost reductions as a result of treatment for other drug addictions are found in the criminal justice and social service systems. In addition, they state that treatment effects on employee productivity

> ...clearly indicate that addictions treatment in workforce populations is a good investment which will be repaid handsomely over time in the form of increased productivity and morale, reduced management problems, and decreased utilization of the health care resources that produce such a bite on American industry.[50]

In California, Oregon, and Ohio, recent cost-effectiveness studies have demonstrated that each day of treatment paid for itself "several times over."

In January 1997, the Department of Health and Human Services published an analysis of California data by researchers from the National Opinion Research Center and The Lewin Group which focused on the outcomes of AOD treatment for parents and welfare recipients.[51] The major findings included:

- The measured benefit to taxpayers exceeded the cost of treatment by 2½ to 1 for women with children on welfare; these benefits were lower than those among men because women initially committed less crime than men.
- Among women with children who received welfare income, the percentage who sold or helped to sell drugs dropped by about 60% and the number who were arrested, booked, or taken into custody dropped by about 54%.
- An average treatment episode lasted about three months, cost about $1,400, and yielded benefits to taxpayers during and after treatment worth about $10,000.

Recent work at the state level has confirmed these national findings. A California-based study of 1994 showed a savings to taxpayers of $7 to each $1 invested in treatment.[52] Oregon's 1996 study found a $5.60 to $1 cost ratio.[53] Ohio recently completed a four-year study on the cost effectiveness of alcohol and other drug treatment. Using analysis of 6- and 12-month follow-up data, the study found that treatment paid for itself "several times over" in social savings, with cost offsets ranging from three to seven times the costs of care.[54]

For all this evidence of treatment's cost effectiveness, it remains important that the AOD treatment field not over-promise what it can deliver. Cost-benefits in the aggregate are no guarantee that a specific client will succeed in treatment. It does not weaken the credibility of treatment to point out the facts: treatment does not work for all clients all of the time. In fact, it may enhance the credibility of treatment to admit that treatment outcomes vary for numerous reasons.

The issue of effectiveness is how we define success—is it abstinence from all AOD use, or is it effective performance on the job and good parenting?

What, then, should be expected from treatment? For people unfamiliar with the treatment system, the most frequently asked question is "how often is treatment effective?" The question is asked as if a single percentage answer would suffice, and in fact, some in the treatment field are willing to generalize and say that "one out of eight" or "one out of three" or some other percentage of those entering treatment are "successful." But the question is more like asking how many parents are successful in parenting than it is asking how many clients complete job training and get a job. At the intersection of the income support, child welfare, and the AOD treatment systems, there are really three closely connected questions: how well is the worker performing at a job, how well are clients caring for their children, and how successful is treatment? The issue is how narrowly we define success—is it abstinence from all AOD use, or is it effective performance on the job and good parenting?

Some programs insist on abstinence as the clearest test of job readiness and parental competence, while others believe that improvements in life skills are the more appropriate measure. The latter point out that millions of middle- and higher-income parents use drugs and alcohol without ever encountering the criminal justice or protective services system, even though their use may at times affect their parenting and, in the case of illicit drugs, is illegal and adds to the overall drug problem.

The competing philosophies of abstinence and "harm reduction" frame this debate between a perspective that complete abstinence is an addict's only hope of recovery versus a view that the ultimate impact on the family should determine how parents are treated by service systems following AOD treatment. One statement of this goal is "abstinence is the treatment goal for any client who is AOD-dependent, yet there are clear and appropriate strategies to reduce the harm associated with AOD use when a client is not abstinent."[55]

In recent years, the demand for greater accountability for results and the advent of managed care in both mental health and substance abuse has created a body of evidence about treatment effectiveness that is far deeper than what was available as recently as ten years ago. Health care companies compete actively for state and county business based on their outcomes, and a wide range of software, management systems, and public "report cards" have been developed that provide far better documentation of the results of treatment programs than was available a decade ago.[56]

Much of what we know about what kind of treatment works for which clients comes from this body of outcomes data. It is important not to overstate what is being done: few states and communities have implemented results-based funding in a comprehensive way based on outcome data. But information systems have been significantly upgraded, and welfare-AOD agency discussions can build upon an improving state of the art in negotiating results-based funding contracts for treatment.

So we have improving data systems, with much work yet to be done, to tell us about the relative effectiveness of treatment programs. But for how many *will* treatment succeed? Each state's experience will vary. But the evidence from the outcome data and the best state and local practices argues strongly that *enough will succeed to justify the investment* – which will have long-term intergenerational impacts going well beyond the two-year and five-year limits in the new law.

Factors that Affect Treatment Outcomes

In a recent review of treatment outcomes, 11 factors were identified as critical variables.[57] These variables are listed in Appendix 6. Two things are clear: (1) welfare clients in many cases will fall into the harder-to-serve group; and (2) these clients will therefore need more intensive services, and in some cases, more time to succeed in moving to work.

Falco has discussed the factor "time in treatment"as it influences outcomes:

> Most Americans don't realize that treatment indeed works, although not always, and often not the first time. Success rates are higher for people with stable families, employment, and outside interests, and lower for those who suffer from serious depression and who do not have solid opportunities. But the single most important key to success is length of time in treatment. National studies which have followed tens of thousands of addicts through different kinds of programs report that one-third of those who stay in treatment longer than three months are still off drugs a year later. The success rate jumps to two-thirds when treatment lasts a year or longer.[58]

Obviously, some clients enter treatment with more positive factors than others. However severe their addiction, clients with a job history and supportive families are very different from clients who lack both. As posed by the 1990 report from the Institute of Medicine, the question of "what works?" may be better phrased as "what works for whom?"[59]

Treatment success requires quick identification of clients who need a more intense level of care. Early signs of treatment success include: (1) level of participation in treatment sessions; (2) participation in recommended self-help groups; (3) results of alcohol and drug testing; and (4) level of involvement of significant others.[60] If these signs are not positive during the course of treatment, the client's level of care should be re-assessed to determine if more intense services are needed.

A further factor affecting treatment outcomes is clients' compliance. In other health regimens requiring major behavior changes, which also have public health cost effects, client compliance is considerably less than universal. Diabetes and hypertension control offer some useful parallels: less than 50% of diabetics comply with their medication protocols, and less than 30% of persons with high blood pressure comply with their medication and prescribed diets.[61]

Steps to Implement Effective Treatment

Each state AOD agency is at a different stage of implementing these newer criteria for levels of care and monitoring treatment outcomes. Welfare and AOD agencies will need to work closely to achieve shared outcomes. The following are suggestions for beginning this work.

- Determine if your state agency uses levels-of-care criteria to assist treatment providers in matching clients to the various intensities of service. Be aware that often these criteria have been implemented only for the Medicaid population, which may affect TANF recipients' ability to enter treatment programs.
- Determine if the range of services needed by clients is available in their geographic regions. Do treatment providers need incentives to assist them in developing a continuum of care?
- Identify your state's providers of treatment for women's specialized services. Identify which specialized services for women need to be added to treatment agencies (e.g., child care, transportation, medical services, others).
- Ensure that data systems are in place or are being planned to monitor treatment outcomes. Can the welfare agency and the AOD agency talk the same language in data collection? If not, make efforts to link those information systems.
- Collect data in your state on the effectiveness of treatment. Determine which non-AOD agencies derive the greatest cost-offsets from AOD treatment.
- Identify which treatment providers have a track record with harder-to-serve clients. What expertise can they offer to the welfare agency and to other treatment providers to work with TANF clients? Determine other linkages for supportive services that need to be made to ensure that additional supports are available for clients when they are needed.
- Consider the public's expectations of the outcomes of treatment. Welfare and AOD agencies must work together with the media and policy leaders to help shape those expectations.

To sum up, it is possible to view the controversy about the effectiveness of treatment as a classic "half empty, half full" debate. Proponents of treatment perceive the undeniable benefits provided to some clients and to society, while critics tend to emphasize the reality that some clients, including those with other personal barriers in addition to their AOD-related problems, are less likely to succeed in recovery. In the context of welfare reform, planners must realistically assess the barriers facing welfare clients and weigh them against the likelihood that a significant number of clients will be able to overcome those barriers if provided the right kind of treatment.

Planning Element 3: Funding for Treatment Programs

Productive dialogues between welfare agencies and treatment agencies are sometimes difficult because each side assumes that funding for treatment should come from the other agency. AOD providers assume that welfare reform will require increased spending on support services for harder-to-serve families, while welfare agencies assume that AOD-using parents will be given a higher priority in the caseloads and funding of treatment agencies. These discussions tend to focus initially on funding from allocations under P.L. 104-193 and from the Substance Abuse Prevention and Treatment Block Grant.

But the funding picture for AOD treatment is more complex, involving more than these two sources alone. Funding for AOD treatment has a categorical history in which health, mental health, and substance abuse agencies have allocated different funding streams for different populations, drugs, and forms of treatment. While the AOD state agencies control the Substance Abuse Block Grant, in some states substantial funding comes from other federal and state sources, including Medicaid. Not all states include Medicaid coverage for AOD treatment, and very few cover a full continuum of care. But in the aggregate, non-Block Grant sources of funding for treatment are significant for some states. In addition, some treatment providers also use food stamps as a partial funding source for room and board costs for residential treatment.[62] The following table shows the FY1994 total expenditures reported for state-supported AOD services by funding source.

Source of Funds	Total Expenditures	Percentage
State AOD Agency Funds	$1,259,681,000	31.7
Other State Agencies	$ 265,922,906	6.7
Substance Abuse Block Grant	$1,105,397,881	27.8
Other Federal Funds	$ 378,226,935	9.5
County/Local Agencies	$ 247,385,049	6.2
Other Sources	$ 723,018,293	18.2
Total	$3,979,632,855	100.0

Source: National Association of State Alcohol and Drug Abuse Directors[61]

The funding system is further complicated by the existence of two tiers of public and private supply of AOD treatment—one for the lower income clients of public systems and one for those who can pay with private insurance or their own resources. While the line between the two has blurred somewhat with the increasing *provision of services* to public clients through private managed care firms, the *financing* remains bifurcated.

Under TANF, these fragmented funding streams will remain a challenge for program planners attempting to orchestrate an interagency response to clients' needs. There are two problems: the first is that states now decide the connection between TANF and Medicaid eligibility whereas previously AFDC and Medicaid entitlements were linked. Second, in the TANF legislation itself, there is a prohibition on use of TANF funds for "medical services." This may add to the strong incentives to build on states' experience in using Medicaid as a source of AOD treatment funding, since Medicaid remains an entitlement while TANF funding is capped, so that Medicaid funds used for treatment can generate additional federal matching.

Although Medicaid has not been a major source of publicly funded treatment, some states have moved to expand their use of Medicaid for AOD treatment in recent years. As of 1993, the vast majority of states (46) cover detoxification in inpatient settings under Medicaid; some also cover it as an outpatient service.[64] A growing number of states cover intensive outpatient services, and 30 cover day treatment programs. States have widely defined these programs, including counseling in most programs and various limitations on the number of visits. In Ohio, for example, the therapy portion of certified residential programs is covered by Medicaid. Some states have recently expanded the enrollment of certain AOD treatment providers as qualified Medicaid providers. States have also used federal authorization to target substance-abusing pregnant welfare recipients, using case management services to provide and target these special services to this population.

An additional complication is the federal prohibition on use of Medicaid funding in "institutions of mental diseases" with more than 16 beds, which has meant that non-hospital residential treatment settings are excluded from Medicaid. An interpretation that infants count against this limit on beds restricts the program even further, resulting in prohibitively high costs for such programs. This has been a major issue for state AOD agencies in their negotiations with DHHS in recent years; states have responded by limiting inpatient substance abuse coverage to short-term detoxification and hospital services, with the dual effect of driving up costs and reducing the range of reimbursable services. This issue may become even more important as states try to place welfare recipients and their children in residential treatment settings. While such a family could be removed from the welfare rolls and deferred from time limits and work requirements while in treatment while maintaining their Medicaid eligibility, the exclusion of some residential facilities would limit use of this programmatic option.

Funding issues also include the *capacity* of the current system to respond to current and projected needs for services. As stated in the 1996 National Drug Control Strategy:

> According to HHS, in 1994 approximately 3.6 million people had drug problems [it should be noted that the National Drug Control Strategy presently has no jurisdiction over adult consumption of alcohol] severe enough to be likely to need drug treatment services. Of the 3.6 million, about 1.85 million actually received treatment in 1994. The difference between estimates of the number needing treatment and the number receiving treatment left a "gap" of about 1.7 million persons likely to need treatment in 1994. Of the 1.7 million, approximately 1 million may be in need of publicly supported treatment.[65]

The issue of capacity raises the further question of which funding sources to use for which clients. With the limitations on Medicaid funding described above, there is a definite tension between the need to assign AOD users to the most appropriate placement and the limitations on funding that create a built-in funding bias toward the least expensive services. The partial solution, as some states have demonstrated, is to carefully assemble a woven-together, "wrap-around" package of funding that combines Block Grant funding, state general funds, Medicaid, and other sources. States thus far, however, have focused these clusters of funding on high-priority clients such as pregnant AOD users and intravenous drug users, not the full range of clients.

A funding mechanism in the TANF legislation allows flexibility for the state to transfer up to 30% of their grant funds from the TANF block grant into the Child Care Block Grant and the Social Services Block Grant (SSBG); states are restricted from moving more than one-third of their transferred funds into the SSBG. This allows the states, within these limitations, to use TANF funds for the 29 federally allowable services under the SSBG. (It should be noted, however, that P.L. 104-193 cuts the SSBG by 15%.) Among the 29 allowed services that are important for AOD clients are case management, counseling, child care, housing services, substance abuse services, and transportation. In 1991, 14 states used a portion of Title XX for substance abuse services. Among the 29 states reporting in 1995, 10 states (Arizona, Connecticut, Illinois, Indiana, Minnesota, Mississippi, Missouri, New Jersey, North Dakota, and Utah) reported using Title XX for substance abuse services.[66]

If TANF recipients are a shared federal and state priority, a broader intergovernmental funding strategy might be possible. Such a strategy would take advantage of these "wrap-around" models, recent lessons with waivers, the Oregon Option, and other federal strategies that have given states and communities new flexibility based on outcomes rather than categorical monitoring. This approach to "bottom-up block grants" seeks to construct customized combinations of funding streams based on a specific state or community's commitments to outcomes. Combining TANF funds, Substance Abuse Block Grants, Medicaid, and other sources would seem to be an ideal demonstration of this capacity for flexibility and results-based accountability.

None of these funding strategies by itself is adequate to meet the needs of AOD users among the welfare population, but in combination and with added flexibility, these strategies could substantially expand states' ability to meet this need and to use categories to meet clients' needs rather than forcing people to fit into categories. But as long as the separate rules of each of these

systems are allowed to function in isolation, the rules will remain the barrier to the optimum outcomes. Greater state discretion to combine categorical funds, linked to commitments to outcomes, may be critical to meeting the needs of AOD abusers among the TANF population.

The Impact of Managed Care

Funding has been further complicated in recent years as a substantial portion of the welfare caseload has moved to Medicaid managed care programs. Some managed care providers have done a good job of seeking and serving AOD users. But as one state welfare administrator put it while discussing welfare-AOD linkages, "managed care providers don't go out looking for addicts." Managed care health providers may present obstacles to getting treatment for addicted parents because the patient's AOD problems are not recognized in the primary care setting, treatment is not covered, or because there is not an incentive to treat this population since a significant portion will disappear within two years, due to TANF time limits or the high geographic mobility of this population. Turning over a Medicaid caseload to a managed care firm should not prevent a state from defining health outcomes against which it will monitor such contracts. Several states have successfully negotiated a "carved out" benefit package covering AOD treatment—in other words, they have separated the contracting and payment authorization for AOD treatment from primary health managed care. Therefore, state planners should review AOD treatment coverages that may affect TANF clients who will come under managed care, and take steps to ensure that adequate AOD treatment coverage is in place. The accessibility and outcomes of AOD treatment are issues that need careful negotiation with managed care providers.

The Total Level of Spending on Treatment

Finally, knowing the magnitude of funding helps place these discussions in context. The total federal spending for "drug control" in FY97 is approximately $15 billion, of which domestic law enforcement makes up $8.3 billion, interdiction makes up $1.4 billion, international activity makes up $400 million, and demand reduction —treatment, prevention, education, and research—makes up $5 billion. Treatment makes up about 60% of the $5 billion for demand reduction.[67] When estimates for state and local spending on treatment are added, state reports suggest that states and localities spend more than $2 billion from their own revenues, which would raise total public spending on treatment to approximately $5 billion.[68] These categories are not iron-clad: when providing services to the entire family, what is "treatment" for a parent may serve as the most effective kind of "prevention" for a high-risk child.

State planners preparing for decisions on AOD treatment should be aware that there are extensive data showing that *the total costs borne by social services systems and the criminal justice system due to* ***alcohol*** *abuse are substantially greater than those attributable to drug abuse.* The best estimate of total costs was based on 1990 figures, and found that the total costs due to alcohol (including treatment costs, other health costs, costs of lost productivity, costs of crime related to alcohol, and other costs such as automobile accidents) were $98 billion, while drug abuse costs were $67 billion.[69] The annual deaths due to alcohol are approximately 100,000,[70] while deaths attributable

to drugs are around 20,000.[71] While the data are not conclusive on whether these proportions are the same in the welfare population as in the general population, the higher visibility of the drug problem should not obscure the importance of the alcohol problem.

Steps to Identify and Allocate Funding

State agencies planning implementation of welfare reform should consider the following steps:

- Review total spending on treatment from all sources, including those outside the treatment agency itself. Recruit to the interagency effort staff members who are familiar with the ins and outs of these several funding streams.
- Familiarize the team with the available data in the state (or available from other states' relevant data) on cost offset studies—whose clients will welfare recipients *not become* if they become employed?
- Negotiate shared costs among agencies—welfare agencies, treatment agencies (possibly with revised priorities for welfare clients), and other agencies likely to benefit in the longer run. Agree to renegotiate these shared costs as better data are produced during implementation.
- Review all available non-TANF funding sources that may be needed for support of AOD users to extend the time needed for effective treatment and aftercare in view of the 24-month time limits.
- Agree upon a commitment to results-based funding from the outset as the best means of ensuring that scarce funds for treatment are used to maximum efficiency and effectiveness—and for convincing skeptical legislators and others that treatment is not an idealistic programmatic hope, but a carefully monitored, fiscally responsible strategy.

Planning Element 4: Defining "Job Readiness"

The legislative intent of the welfare reform bill is, with some important exceptions, to allow states to define their own priorities. The new legislation actually contains three separate work requirements, and all three may have an impact on AOD-abusing clients, depending on how states define "job readiness."

Complying with Work Requirements

The first work requirement is the community service requirement, which is imposed after two months (unless the state opts out, which may be done by simply notifying the Secretary of DHHS). The second requirement is the two-year limit on receiving aid without working, which is a basic feature of the bill's time limits. The two-year work requirement applies once the state determines that the parent is "ready to work" or after 24 months of benefits, whichever comes first. "Ready to

work" is to be defined by the state, however. The third requirement is the work participation rate measured at the statewide level, which requires at least 20 hours a week of allowable work activities to count toward the work participation rate.

States at this point perceive the first two as less onerous because states have more discretion in dealing with the first two, with no specific penalties for failing to meet them. In contrast, the states can lose substantial funding for failing to meet work participation rates. This creates added pressure for states to place recipients in work as rapidly as possible, and may undercut efforts to devote adequate time and resources to treatment, either as a precursor to or simultaneous with beginning work. In federal legislation, job readiness assistance is to be available for only six weeks and is restricted to job search preparation, job coaching, and interview skills.

Job readiness is a concept that needs to be closely linked to the issue of *clients' different stages of both AOD dependence and employability,*[72] since different clients have different barriers to work based on their addiction and other employment-related issues (as discussed in the prevalence section above and further in the appendix). The work requirements need to be administered in a way that takes these different abilities and needs into account. The Research Triangle Institute (RTI) has recently developed a vocational readiness screening instrument which identifies vocational and other service needs among AOD treatment clients. The instrument assists vocational specialists to determine if the client is: (1) non-vocational; (2) pre-vocational; (3) training-ready; or (4) job-ready. This instrument and RTI's documentation may be helpful to states to develop assessment protocols of clients' readiness to work.[73]

Critics of the work requirement argue that it does not really provide the resources to make the work requirement a serious effort; states could, in fact, satisfy the work participation rate requirement simply by cutting off aid to some families, since a "caseload reduction credit" counts toward meeting the rate requirement. The state's work participation rate requirement is reduced by the number of percentage points of decline in the state's caseload since FY95. However, this strategy seems likely to simply transfer the welfare costs to the other health and social service systems.

So a critical choice to be made by the state is how to treat AOD use as it affects a client's job readiness. As this report has pointed out, the depth of screening and assessment will determine how much the agency understands about the treatment needs of individual AOD-using TANF recipients. A possibility that has been raised by some states is for the federal government to extend the definition of allowable work activity to include AOD treatment. This would place treatment in the same category as vocational education; it could not exceed 12 months and would be included in the states' 20 hour work participation rate. This issue should be addressed in the technical amendments to P.L. 104-193.

From Treatment to Employability

For some clients, combining work and treatment will be appropriate. For others who are more severely affected by their addiction, treatment will have to come first, since they will be initially

unable to function at the workplace, and working regularly may not be practical until progress has been made in treatment. For these clients, work requirements will be a greater problem because their treatment-only time is unlikely to count as work.

The most likely options for the larger group of clients who will be able to *combine* work and treatment (in light of the DHHS estimates for the smaller group of AFDC women who were "significantly" impaired and another, larger group who were "somewhat impaired") will be either short-term, intensive treatment followed by work, or various forms of treatment provided while the client is working. Again, it is important to note that the levels of intensity of treatment vary widely, as described above in discussing treatment options. A significant number of recovering people work daily and attend therapy or self-help groups in the morning or evenings. Effective aftercare programs will usually include some kind of support program that may even be held at the workplace in larger companies.

What needs emphasis is that *treatment is not in itself job readiness*; it is a critical element of attaining job readiness. For some clients, treatment can occur concurrent with work. Although AOD treatment by itself does not ensure that a parent can keep a job, it can be a critical prerequisite to job readiness.

It should also be noted that exceptions to the work requirement are allowed for parents of disabled children or if one parent is disabled; the overlap between the mentally ill portion of the caseload and AOD-abusers may be an issue that states would want to assess in making judgments about this disability criterion.

States' past experience cannot be ignored in considering the new work requirements, since prior (pre-P.L. 104-193) law gave states the authority to require 70% to 80% of AFDC parents to participate in work programs and to penalize those parents who fail to do so. However, only about 20% of AFDC adults are working or participating in work-related activities. Both the lack of resources for job readiness activities and the multiple barriers faced by some of these parents have been cited as explanatory factors.[74]

Steps to Implement Job Readiness Provisions

- Determine how the state will respond to the community service requirement.
- Using assessment tools described, determine which AOD clients are job ready. Use assessments to distinguish between clients who can participate in work activities while also participating in treatment and those who need to attend full-time treatment prior to work activities.
- Review the existing range of treatment options for clients simultaneously participating in treatment and work activities to ensure that the continuum of programs is available and accessible.
- Monitor possible federal expansion of the definition of work participation.

Planning Element 5: Addressing the Needs of Children

Welfare administrators understand the obvious fact that two-thirds of the welfare caseload are children and that one out of seven American children was on AFDC. But for the children of AOD-abusing parents, the reality is deeper: *these are the children most likely to become AOD abusers themselves*, creating tomorrow's caseloads. As noted above, treatment for the parents of these children is one of the most effective forms of prevention.

Within the treatment system, the history of categorical funding has never emphasized the impact of addiction on children and families, since funding has emphasized the type of drug or treatment rather than family composition. Most treatment agencies cannot tell how many children are affected by their programs, since their databases rarely include the presence of children in the families of their clients. This is the "missing box problem": there is no place on the AOD treatment intake form or in the cumulative AOD databases that accounts for the inclusion of children in the caseload. In responding to addiction, which is an intergenerational family disease, this is a critical omission.

The further complicating factor is the prevalence of abuse and neglect of children among AOD-using welfare clients. National and states' estimates of the percentage of child protective services (CPS) population who are in the AFDC program range from 5% to 21%.[75] Of the children in foster care nationally, about half are from AFDC-eligible families; state-by-state, the percentage varies from about 25% in low-benefit states to more than 80% in New York. The national estimates of the number of families in the child protective system who are also affected by substance abuse ranges from 50% to 80%.[76] These estimates strongly suggest that the abuse and neglect rate is much higher among the AOD-abusing portion of the welfare population.

Since foster care remains an open-ended entitlement, some states have expressed concern that incentives to remove children from families may be increased. Obviously, the overlap between CPS, TANF, and AOD issues is an important one, complicated by three different funding streams. In addition, improved screening and assessment of families in TANF may open up additional CPS cases, since we will end up knowing more about clients' AOD problems and their parenting. This may create a major disincentive for parents to participate in the supportive services they need, since honesty in answering questions about their past drug use may result in banning them from the program for life under the Section 115 prohibitions.

Separate from the continuing assessments of AOD users' progress in treatment, there also needs to be a continuing assessment of their parenting and their family functioning as it affects their children. These disincentives may be avoided if family support services are available and connected to the TANF support services system; many studies have pointed out how the threat of a child's removal for abuse or neglect may provide the right combination of incentives and demands for a family to seek support.[77] Child protection is an unavoidable issue in considering the impact on children of AOD policy and the welfare system.[78]

The child welfare system, TANF, and AOD treatment observe very different timetables. The TANF two-year clock on benefits is inconsistent with both the 12- to 18-month parental rights termination clock in the child welfare system and the faster clock recommended for parental terminations in the case of younger children.[79] The AOD "clock" sets up another timetable, monitoring clients against the longer period needed for recovery. The responsible agencies must work together at state, federal, and local levels to maximize their ability to assist families based on a more consistent set of rules.

The Potential Significance of Fathers

For all the emphasis on welfare outcomes for women and children, it should not be assumed that fathers and other male caregivers are irrelevant. Three factors make them significant: (1) the fathers of some children on welfare are attempting to be better providers, both of their own free will and under pressure of stronger child support enforcement—but some will need assistance in the form of AOD treatment; (2) the highest cost-benefits of AOD treatment come in crime reduction among male AOD abusers, as noted above; and (3) some of these fathers will be affected by welfare reductions that affect General Assistance recipients, as states and counties consider reduction or elimination of their General Assistance programs. A painful tradeoff has begun to emerge in some areas between greater attention to welfare-receiving mothers with children and the needs of single men. The partial overlap of these populations and the potential cost effectiveness of treating fathers who are seeking to help their families should be reviewed before any choices are made between mothers and fathers of poor children, especially if both parents are seeking to work and to be effective parents.

Planning Element 6: Decisions Regarding Felony Drug Offenders

The provision in the welfare reform legislation (Section 115) that prohibits provision of services to persons convicted of drug-related felonies (the "Gramm amendment") creates special challenges to states.[80] In sum, the provision permanently ends eligibility for cash assistance and food stamps for anyone convicted after August 22, 1996, of a felony crime that involves possession, use, or distribution of a controlled substance. States may opt out of this provision. This possibility has been proposed as legislation in Washington State (by the outgoing Governor) and in Oklahoma. Florida has received approval from a state-wide board, which is overseeing the implementation of welfare reform, to opt out of this legislation. Under this proposal, convicted felons would be eligible for benefits provided they are in a state-licensed treatment facility and making satisfactory progress as determined by the state. It will require legislative action to adopt this proposal. It is also under consideration in other states (e.g., Kentucky), which have proposed mandating that anyone with a felony drug conviction must be in treatment to receive TANF benefits.

Given the more detailed information available from screening and assessment tools (compared to drug testing), these assessments, rather than a blanket prohibition, should determine what should happen to those welfare clients with such histories. It is clear, however, that if states do not exercise the option to forego this provision or to target it solely on offenders who refuse treatment, a small but potentially significant segment of a state's population will be excluded from benefits. This

provision is complex, and the reader is referred to the New York or Washington, D.C., offices of the Legal Action Center, which has undertaken more in-depth analysis of the issue.

While both state and federal felonies are included in the provision, each state determines the specific circumstances under which a person is charged with a felony or misdemeanor. Determining the number of TANF recipients who will be affected by this amendment is not straightforward, nor is it readily available by gender.

Annual Drug-related Felonies				
	State Convictions[81]	Federal Convictions[82]	Total	Estimated Women
1990	274,613	16,311	290,924	43,638
1992	280,232	18,848	299,080	44,862
1994	274,245	17,722	291,967	43,795

The percentage of the women with drug convictions who would request TANF after completing their sentence is not known. However, this number represents approximately 1% of the women on AFDC in 1993. Washington State has estimated that there would be approximately 340 households ineligible for cash aid and food stamps with another 240 households ineligible for food stamps only.

Planning Element 7: Working with Other Needed Partners

The connection between the welfare agency and AOD treatment agencies is not the only linkage needed to make the welfare-to-work transition effective. During and after treatment, recovering addicts and alcoholics need child care, job training, and a host of other services. TANF clients with the greatest barriers to employment are likely to be in other agencies' caseloads already, or eligible for those agencies' services whether they are receiving them or not. As a result, bilateral "treaties" between welfare agencies and treatment agencies may lack sufficient interagency collaboration to ensure provision of the services these former welfare clients may need most. As one state welfare staff member said recently, "Drug and alcohol treatment is not a stand-alone service."

This argues for a collaborative, interagency process at both state and community levels to work out these linkages and priorities, rather than relying solely upon the welfare agency or bilateral relations between it and other agencies. Some states have set up such interagency planning teams for implementing P.L. 104-193. But a continuing question is how effective these bodies will be in ensuring a parallel process at the community level—not only in those states that have county-administered welfare systems, but in those where AOD treatment providers are concentrated at the local level.

Early childhood development agencies are important allies, since funding for child care expansion is expanded for many states. Determining priorities for these funds could be based in part upon a

family's potential strengths, rather than its deficits. Commitments to younger children can be such a strength. The demonstration projects referenced above (in which Head Start provided substance abuse prevention services to selected parents) provide a base for such efforts. These programs recognized that parents with AOD problems may be given the greatest incentives to stay in treatment through a program that is both child- and family-focused, rather than solely addiction-based. Additional lessons are still very fresh from the successes of the best of the perinatal projects in promoting both recovery and early childhood enrichment.[83]

Parents with AOD problems may be given the greatest incentives to stay in treatment through a program that is both child- and family-focused.

Connections should also be forged between welfare reform efforts and the growing network of family support programs. They could include both informal family support programs and more formal institutional activities such as family resource centers, school-linked services programs, and home visiting programs.[84] These programs could provide some AOD treatment clients with the added, informal support needed to overcome other barriers to success in work and parenting.

Business is an important potential partner in addressing the needs of AOD abusers in the welfare population. As federal and state officials exhort businesses to hire welfare recipients, the responses will in some cases affect AOD users. Some businesses have made a special effort to hire and support recovering workers, either out of a conviction that it is a social responsibility of business, that is a source of well-motivated workers, or based upon the personal history of leaders and others in the firm. In some communities, it will be important for both private businesses and public employers to address their hiring practices in tandem, since public employers such as school districts are the largest single employers in many communities and can set the tone for other employers.

Changes in the Delivery System

The welfare reform legislation has created opportunities for both religious organizations and for-profit companies to become more actively involved in welfare-to-work efforts. Section 104 of the bill provides states with the option to contract with "charitable, religious, or private organizations," and to provide clients with "certificates, vouchers, or other forms of disbursement which are redeemable with such organizations." The section adds nondiscriminatory language that seeks to prohibit any discrimination against organizations based on their religious character.

This invitation to religious and for-profit organizations may significantly impact the AOD treatment delivery system. Many religious organizations and members of faith communities are involved, both institutionally and individually, in recovery work. National and local organizations provide extensive support services to recovering persons through religious frameworks. If AOD agencies make an effort to supplement their treatment services with the supports available through these organizations, an important form of added reinforcement and aftercare may be available for some clients.

The opening to for-profit providers seeks wider privatization of welfare program management. Its impact upon AOD users could be through the expanded use of managed care firms discussed above. Potential partnerships may emerge, based on comparative advantage and mutual needs, between for-profit health care providers and community-based organizations, which could be much more effective in providing outreach and follow-up services that are culturally competent and geographically targeted. As welfare and AOD agencies negotiate their working relationships, this wider set of impacts on the delivery system should be considered, since welfare reform will be the single largest social policy change affecting existing delivery systems in many communities.

Planning Element 8: Measuring Outcomes of a State's Response to Welfare Reform

In addition to mutual responsibility contracts with welfare clients, states also need a contract with the public for accountability, expressed through independent evaluation of reform efforts. Some states have been proponents of federal welfare reform, and some have opposed certain features, but both sides have predicted some very specific changes. The assessments that follow implementation must include community-wide measures in the form of "score cards" that will help states and their communities determine the actual impact. These community-level outcomes can become local versions of the benchmarks that Oregon and other states and counties have begun to use to allow the public to understand and track what is happening to achieve new priorities such as welfare reform.

The best measures of welfare reform are not job placements or reduced births to unmarried teens, but the well-being of children living in low-income families.

Wade Horn, previously the Bush-appointed head of the Administration on Children, Youth, and Families, has recently written that the best measures of welfare reform in the devolution era are not job placements or reduced births to unmarried teens, but the well-being of children living in low-income families.[85] This priority seems appropriate, but the question then becomes what measures are used at the community level to track those changes over the next five to ten years. Regrettably, very few American communities have such a process under way, and only a few states are helping their localities develop such measures. A few communities, however, have used tools such as the Healthy People 2000 indicators, a separate set of AOD indicators proposed by Brandeis University for the Robert Wood Johnson Foundation, and other community-wide measures such as the Minnesota Milestones and the Oregon Benchmarks to monitor changes in outcomes at the level of the whole community.

The outcome measures used at agency and program levels will also be very significant in assessing the impact of welfare reform. As the history of the Job Training Partnership Act makes clear, measuring job placements is very different from measuring how many clients become employed *and keep those jobs* for more than six months. It is much easier to get AOD users temporarily placed in an entry-level job than it is to keep them there. To attempt to save money by cutting back on treatment services may result in poor outcomes, which will be most apparent if the outcomes selected by states are thorough in assessing what really happens to welfare clients and their children after they go to work.

III. State Experiences and Program Models

States and communities can draw upon existing models in addressing the problems of AOD-using welfare clients. Several states have launched special training programs for staff, innovative family support and home visiting programs, and new screening and assessment protocols. While some of these model programs are not focused directly on the AFDC population, the clients they serve overlap significantly with this target group.

During January 1997, we contacted 41 state alcohol and drug agencies to determine what models were being operated or were planned to address AOD problems in welfare reform. We received responses from 32 states. Highlights of the responses follow, along with details on specific state initiatives obtained from other sources. (This section also draws on an informal DHHS review of the first 39 plans received from states; of these plans, 14 specifically mentioned alcohol and drugs.[86])

A major investment in staff development and training has been under way in **Sacramento County, California** with support from the Annie E. Casey Foundation. In 1993, the Department of Health and Human Services enacted an initiative to incorporate AOD services as an integral part of its service delivery systems. The program has three components: (1) three levels of training to develop the ability of social workers, public health nurses, eligibility workers, and neighborhood-based service staff to provide treatment services to AOD-using clients; (2) the expansion of department and community resources, including the development of an automated service requisition and client tracking system; and (3) program evaluation including both short- and long-term outcomes related to family functioning (reduction in Child Protective Services referrals, and success in completion of either voluntary or court-ordered treatment plans). By January 1997, over 1,200 health and human service staff members had participated in the training with positive effects shown on the interim evaluation. The net effect for Sacramento County has been an increase in alcohol and drug treatment slots, significantly reducing waiting lists. Sacramento County is currently offering its training package as well as technical assistance to other locales.[87]

Connecticut recently enacted legislation in which women receiving AFDC and/or General Assistance funds who enter AOD treatment without their children must forfeit all welfare benefits. Those women who enter AOD treatment *with* their children must pay part of the cost of their treatment (generally, up to one-third of the total cost). Women with children who are enrolled in a job-training program receive a cash stipend to be used toward child care expenses. Women with children who are receiving AOD treatment services are given no child care stipend. The AOD Department is currently implementing standardized assessment protocols for the non-AFDC clients with a long-term goal of standard assessment criteria statewide. The Department of Children and Families (DCF) has a program providing central intake, priority access to drug screening, substance abuse evaluation, and a variety of outpatient addiction services for the primary caregivers of children in their protective services caseload. Approximately 60% of clients follow through with their evaluation, and 60% to 65% of them are assessed as needing AOD treatment. Fifty percent of those referred for an evaluation to this program are AFDC Medicaid clients. DCF funds the screening and drug testing component.

Delaware received a federal waiver allowing them to use Title IV-E funds from the Social Security Act for AOD treatment. (Oregon also has received the waiver.) Using this waiver, Delaware has been able to staff joint CPS-AOD teams to provide services to families whose children might otherwise have to be placed or remain in foster care. Delaware also operates under a "no wrong door" policy for its human services clients, using multiple entry points to the health and human services provided by the state, with triage and referral services provided by retrained front-line workers. Delaware has also negotiated an interagency agreement with its vocational rehabilitation department to work jointly with the AOD agency on AOD-using clients.

Hawaii offers an incentive to treatment providers to work with the family unit as a whole by paying more to treat a family than a single individual. Some AOD users are able to enroll in a "Mom/Kids Program" that entitles the child of a mother in residential treatment to be admitted to the program. The children are provided a treatment plan, educational support, and the benefits of child-focused therapy. The state AOD agency also offers an incentive to increase rehabilitation and job readiness activities for clients in AOD treatment by increasing treatment reimbursement rates by $10.00 per patient for programs to increase their delivery of these job services.

In **Illinois**, public assistance clients in three pilot sites who have alcohol or other substance abuse problems are required to participate in a treatment program in order to continue receiving their monthly benefits. The pilots are co-funded with 30% of funds from the AOD agency and 70% of funds from the Public Aid/Welfare Department. An intake worker at the Public Aid Office is trained to perform an AOD screening. If this screening shows a possible issue with AOD, the potential client is referred to a treatment provider to receive an in-depth assessment. If the client does not participate in the assessment, the benefit is sanctioned. The children of sanctioned adults will still receive benefits and the funds may go directly to the adult caretaker or through another payee. The assessment at the AOD provider follows the criteria established by ASAM (specified in Appendix 5). In July 1997, the Department of Alcoholism and Substance Abuse, the Department of Mental Health, the Department of Public Aid, and the Department of Rehabilitation Services will be merged into one department called the Department of Human Services.

Iowa is in the planning stage for addressing AOD in new welfare reform implementation. At present, however, the AOD agency provides the parenting classes for welfare recipients under the age of 18 who are required to participate. The classes are conducted as a component of the AOD prevention programs. They are co-funded by state agencies, including the AOD Department and the Work Force Development Department.

In **Kansas**, a program called KanWork took effect November 1, 1996, and put an emphasis on providing services for welfare clients who need help with AOD problems. The state has implemented a comprehensive screening, assessment, treatment, and outcome monitoring protocol as follows:

- A preliminary screen is conducted at the welfare office. The screen looks for signs of intoxication, dismissal from employment for AOD-related causes, addiction-related legal

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problems (e.g., a conviction for driving under the influence), acknowledgment by the customer that he/she has a problem, or a positive result on a CAGE screening instrument.

- If yes to #1, the customer is referred to the centralized assessment center for a placement assessment. The assessment center uses a SASSI to determine if there is an AOD problem, and uses the Kansas Criteria for Patient Placement to determine the appropriate level of care.
- AOD treatment providers in Kansas use the ASI for an in-depth assessment for treatment planning and baseline data for their outcome monitoring system.
- The AOD treatment provider determines when a client is in recovery. If the client is not participating, a sanction is considered. When a client is in recovery, he/she resumes employment activities.

The assessment and treatment components of the system are funded by AOD sources. The welfare department pays partial costs for drug testing conducted to meet pre-employment requirements of some employers. In addition, the AOD agency works with their child protection agency so that women who enter treatment and cooperate with their treatment plan are not in danger of losing custody of their children. Thus, the integrity of the family is not threatened by the mother's decision to enter treatment services.

Michigan's Family Independence Agency (FIA) and its Department of Community Health's Center for Substance Abuse Services have cooperated through the Michigan Opportunity and Skill Training (MOST) Program and the WORK FIRST program. MOST is an employment skills training program and WORK FIRST is an employment program. FIA clients with AOD problems are considered to have special needs and are required to be enrolled in either MOST or WORK FIRST as a part of their treatment plan. Steps are taken to ensure that the employment/training plan does not interfere with the treatment plan. Michigan received a three-year federal demonstration grant for working with the AOD-using SSI population in 1993. The state is monitoring the impact on SSI recipients of P.L. 104-121, the Contract with America Advancement Act, which terminated SSI for those individuals deemed disabled due to any AOD addiction. The regional assessment centers in Michigan are using the ASAM patient placement criteria, the ASI (discussed in Appendix 3) for adults and the Adolescent Drug Abuse Diagnosis instrument for adolescents for Medicaid clients seeking AOD services. Since the TANF legislation passed, ongoing meetings between the welfare and AOD agency have identified the need for cross-training and prioritizing clients in certain areas of the state.

New Jersey's work group has preliminary recommendations on principles to guide the development and implementation of a demonstration substance abuse and Work First program. These are:

- The goal of any substance abuse treatment should be to enable recipients to become employable and the message of work and a work component should be included in all treatment at all times.

- Although a continuum of job and treatment services should be available, only those services that meet individual needs and that develop employability skills should be provided. Not everyone should be entitled to every service.
- Assessment, education and treatment for children of the women in the demonstration program should be included whenever possible.
- Sanctions and incentives should be tied to outcomes (sobriety, clean drug test, etc.) when possible, rather than based solely on attendance in treatment.
- Case management should be a critical component of the demonstration.

As of mid January 1997, **North Carolina** was in the final stages of developing its plan to address AOD issues in welfare reform implementation. One of the foundations of the plan is the state Employee Assistance Program (EAP) which is a branch in the Substance Abuse Services Division. The current EAP program offers AOD services to private business in North Carolina and will be available for employers who hire former welfare recipients. To provide treatment prior to job placement, North Carolina's plans include placing qualified AOD professionals in each of the 100 county welfare offices to conduct AOD assessments. They are exploring ways to use state funds for clients who are not yet job ready so that TANF time limits begin when clients are ready for work. All of the partners in the planning task force are exploring co-funding the implementation.

Ohio has operated the JOBS Local Linkage Program for five years. Serving 35 of the 88 counties, it is an outreach and early intervention program funded in a 50/50 mix of federal JOBS and local funds. Each project offers training and education on AOD issues to both human services staff and to welfare recipients in addition to AOD screening and referral services to JOBS clients. Through the program, the Department of Alcohol and Drug Addiction Services and Department of Human Services recognized that up to 75% of JOBS recipients reported AOD abuse or addiction for themselves or in their family. In response, the Department of Human Services has provided funding to the AOD department which has conducted an education program focused on the relationship between co-dependence, domestic violence, and the instability of the welfare cycle.

A major state welfare reform initiative is in its first year of implementation in Ohio. House Bill 167 gives the Department of Alcohol and Drug Addiction Services and the Department of Human Services authority to intervene with AOD-abusing or dependent pregnant women receiving public assistance, and it provides funding to refer these women to appropriate treatment. Seven major metropolitan counties are piloting the implementation. Under their interim plan for TANF, no changes in Medicaid eligibility were instituted. Therefore, TANF clients will continue to be covered through OhioCare, the state's managed care plan for primary health with a "carve-out" for mental health and addictions treatment. These managed care plans are part of the Governor's commitment to increase Medicaid eligibility to cover an additional 96,000 children.

Oregon has operated its "JOBS for Oregon's Future" program under a waiver since 1992, and every regional office is required to include plans for addressing substance abuse in their welfare-to-work programs. If substance abuse or mental health problems are interfering with clients' ability to meet

their self-sufficiency plan, they can be mandated to participate in treatment. The majority of district offices use the Substance Abuse Subtle Screening Inventory (SASSI) to screen clients for AOD problems. Staff report that the key to implementing the SASSI procedure is the case workers' presentation of it as an opportunity to create a better life for themselves and for their children. Case managers in welfare offices are assisted by on-site or community-based AOD clinicians. If treatment is recommended by the clinician, it is mandatory, with sanctions applied if recipients fail to follow through for treatment. In the Portland area, treatment providers are linked to 12 pre-paid health plans that work in conjunction with the Oregon Health plan.[88]

South Carolina's waiver includes a provision that drug testing be used on recipients in treatment and following treatment. Identification of those needing treatment was to be on the basis of recent AOD-related convictions, giving birth to a drug-exposed child, or based on the suspicions of the case worker that substance abuse was continuing. As of October 1996, the state proposed testing all 45,000 AFDC recipients. Counselors are assessing clients who do not test "clean" and referring them to a variety of programs. If recipients refuse to seek treatment, they can be denied assistance. South Carolina estimates a 12% to 15% need for some kind of AOD treatment among its welfare clients.[89]

The State of **Washington**'s Division of Alcohol and Substance Abuse (DASA) has used its information system to analyze the links between AOD treatment and the other human services and to document the overlap of clients and costs across the agencies. The DASA and the Division of Child and Family Services are focusing on cross-training their respective personnel. They have established a referral process, including a five-question screening tool for children's services, and they provide inter-disciplinary case planning, case staffing, and aftercare planning. In addition, the outgoing Governor proposed legislation to opt out of the Gramm amendment.

At the **Federal** level, a series of family service center grants have been awarded to assist Head Start programs in addressing AOD problems (and other conditions including illiteracy and unemployment). The Center for Substance Abuse Treatment (CSAT) in HHS has funded residential drug treatment centers for women and children in several sites around the nation. The Center for Substance Abuse Prevention (CSAP) and CSAT have also worked closely with the Maternal and Child Health Bureau in HHS, and this partnership has funded a set of demonstration programs for pregnant and parenting women involved with substance abuse. The National Institute on Drug Abuse funded 20 six-year perinatal treatment research projects assessing treatment outcomes with pregnant women.[90]

Co-payment is a practice that is gaining wider acceptance. A recent assessment of state waiver strategies proposed that planners consider adding a small co-payment, in the form of either cash or bartered services, to the requirement for treatment, suggesting that such a payment offers the best hope of integrating welfare recipients into the mainstream.[91] In fact, growing numbers of family support programs encourage community residents to "pay for" the services they receive with small cash payments or bartered services as a means of adding the dignity of a request for payment to what then becomes a reciprocal exchange between a community and those it decides to help.

IV. Conclusion

The shift toward state responsibility for making the hard choices is not new national policy; state waivers have been expanded under the past three administrations—two Republican, and one Democrat. Choices about which clients should receive priority for supportive services are now more visibly focused at the state level, but for some time it has been state policy that has most determined who is helped. With continuing federal funding, albeit at a capped level, the states' decisions about which of their clients should receive priority attention will largely determine the success of the move from welfare to work. Those decisions will also have a profound impact on children and families.

The problem of AOD-using clients whose use of alcohol and other drugs affects their ability to work and to parent has been an important challenge for a long time; what gives it new urgency is the certainty of time limits in TANF implementation. With work requirements added to time limits, the task of responding to the needs and the efforts of AOD-using welfare clients has become far more pressing.

Practical experience at the state and community levels powerfully demonstrates that the tools and the knowledge exist to do a much better job of responding to this population. This evidence makes clear that personal responsibility and institutional responsibility can be combined in a values-driven set of strategic policy choices. This document has provided guidance to state policymakers who must make the difficult decisions on how to implement welfare reform. While each state will face different circumstances, the critical decisions described in Section II can be flexibly applied to address the problems and opportunities of responding to AOD treatment needs. Such flexible responses will provide long-term fiscal benefits to the states—and equally important long-term, positive impacts on children and families.

V. A Dialogue with the Governor

The Governor had called in two of his key Cabinet members to review the progress of planning for welfare reform. After discussing several of the most difficult issues, the Governor asked "So what do we do about the addicts and alcoholics on welfare?"

The AOD Director responded first. "We need to recognize that these recipients are a big part of the new TANF caseload, and we should get them into our best treatment programs. We are recommending that up to one-third of the funding for supportive services be allocated to treatment programs."

The Welfare Director smiled thinly, and said "If we allocated support services funding to every service that agencies want our money for, we'd have nothing left to get people off welfare and into jobs. This is just one more subgroup within the welfare population and we'll have to see what funds are available." Turning to the AOD Director, she added, "we're also hopeful that other agencies will put some of their *own* money into services, since welfare reform has been one of this administration's highest priorities."

"Well, just how many of these people are there?" asked the Governor.

"The feds say it's barely 5% of the caseload who are *really* impaired," said the Welfare Director.

The AOD Director quickly interjected "But everyone knows that this number is too low. The national and state estimates are comparing apples and oranges—a national survey is one thing but not the same as who really walks into welfare offices. But even the feds said at least 15% *needed* AOD services. If you cite the low-end estimate to people who work in the welfare field—as I have for the past six months—they laugh out loud. The best estimates from other states are in the range of 25% to 35%, and we think our own numbers are in the mid-range of that."

The Governor looked thoughtful, "A lot of people are just going to say throw them off welfare if they can't straighten out their lives and can't get a job because they can't pass a drug test. So why should we worry about this? The new welfare law is clear—the responsibility is on the clients now to do their part."

The AOD Director responded, "But these are some of the highest cost clients who will show up in other caseloads if we just throw them out of TANF. They will also bring down our state numbers in reporting on what we have done to get jobs for welfare clients. If we just place these people in jobs without giving them any kind of treatment, they are going to be the first to get fired for not showing up or failing a drug test.

The Governor looked even more troubled, "I see what you're saying about their turning up in other caseloads and making our numbers look bad. But if they're failing drug tests— why give them any more services or any more time to get off the caseload?"

The Welfare Director spoke up, "We've looked at what some of the states that seem farther along are doing about this, and we're convinced we can work with the AOD agency—using both their resources and ours," she said with a pointed look at the AOD Director, "to develop screening and assessment tools that will help us determine which clients are ready for job-related treatment services, so that we can define job readiness as including alcohol and drug treatment for those clients who need it. But we don't think the 20% exemption should be used for any clients who have repeatedly refused to comply with treatment requirements.

The AOD Director interjected: "A lot of addicts may need more than one round of treatment, though, so we need programs with adequate aftercare to make treatment work."

"Right," the Welfare Director resumed, "people definitely need second chances to battle their addiction, but not eighth or ninth chances. And we don't think it's in the best interest of their kids if they keep failing in treatment and aren't good parents."

"I think I see what you're proposing now," said the Governor. "It sounds like a kind of "tough love" approach—we'll help you as long as you help yourself—and we'll be monitoring your progress and how you're doing with your kids to make sure you are doing your part. Our part is to provide the treatment resources. But do we have enough resources for as many clients as we think we have who need them?"

The AOD Director answered, "We know that not all clients need the most expensive forms of treatment. But it's also true that we already have a waiting list to get into treatment. With a hard look at our joint resources, we can provide the intensive levels of care for the clients who need and that we can assign TANF clients who have less severe problems to the less intensive programs."

The Governor looked questioningly at the two Directors. "It will take a lot of interagency work to make this happen, won't it?"

The Welfare Director answered first, "More than we've ever done before—we need help from every source we can get it from; this is not a program I want to hog for our agency."

The AOD Director added, "We know this will take a different kind of working relationship between the two departments—and that we haven't done enough in the past to work on the problems of the clients we have in both our caseloads at the same time. We're ready to help as much as we can."

"Go to it," said the Governor. "And let me have a joint plan for these clients as a part of your overall implementation effort, as soon as you can."

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Appendix 1
Key Provisions of The Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193) Affecting AOD-using Welfare Clients

The provisions of PL 104-193 that directly mention drug-using recipients (alcohol use is not mentioned directly, although alcohol is a drug and some alcohol-related offenses can be felonies) are found in Section 115 and Title IX. Section 115, referred to as the Gramm amendment, denies cash assistance and food stamps to clients convicted after August 22, 1996, of certain drug-related felonies. Title IX allows states to conduct drug testing in conjunction with operating their Temporary Assistance for Needy Families (TANF) programs. While these two provisions are the most directly related to AOD-using clients, **there are several other provisions that create opportunities for states to address AOD-related problems**. These provisions are highlighted in the table and are addressed in more depth in the text of the report. Additional details on these provisions are available from the Welfare Information Center (http://www.welfareinfo.org), from the Center for Law and Social Policy (http://tap.epn.org/clasp), from the Department of Health and Human Services' welfare website (http://www.acf.dhhs.gov/news/welfare/index.html), or from the Legal Action Center (212 243-1313 in New York; 202 544-5478 in Washington).

Provisions of P.L. 104-193 Affecting AOD Users	
Section 104	*Services Provided by Charitable, Religious, or Private Organizations*
Section 115	*Denial of Assistance and Benefits for Certain Drug-related Convictions* (The "Gramm amendment")
Section 402	*State Plan* State definition of "engage in work" Community service requirement Domestic violence option to exempt
Section 407	*Mandatory Work Requirements*
Section 408	*Prohibitions and Requirements* 20% exemption from 5-year TANF coverage; the "reasonable cause" exception Individual Responsibility Plan option
Section 404	*Use of Grants* Employment placement programs
Title IX	*Miscellaneous* State drug testing option

Appendix 2
Estimates of Welfare Clients with AOD-related Problems

There have been four national and several state-level studies that estimated the number of AFDC clients with alcohol and other drug (AOD) problems. There are several differences between the studies:

- Different age groups have been studied;
- Some used the frequency or type of substance used to define problems;
- Some assessed clients' impairment in functioning;
- Some used criteria to diagnose AOD abuse or dependence;
- Some base their data on AFDC workers' assessments of AOD problems; and
- Some have used AOD screening instruments with their welfare population.

In an evaluation of the applicability of these studies to a particular state, bear in mind that comparing a nationally representative sample of household members with clients who actually apply for assistance is comparing two different populations. Another important caveat is the criteria used to determine that there is an AOD problem. According to the *Diagnostic and Statistical Manual of Mental Diseases: Fourth Edition* (DSM-IV), the difference between substance abuse and dependence is the number of life areas in which a person is experiencing problems related to their use of AOD.[1] This distinction is important because not all clients who fail a pre-employment drug test or who need AOD services to be gainfully employed would meet the criteria of substance abuse or dependence. Highlights of the various estimates follow.

- The U.S. Department of Health and Human Services (HHS) used data from the 1991 and 1992 National Household Survey on Drug Abuse (NHSDA) to estimate the number of women age 15 and over who received AFDC and who were impaired by their use of AOD. HHS found that 4.9% of AFDC women were "significantly" impaired and another 10.6% were "somewhat impaired."[2] Their analysis included the statement that both the seriously impaired and the somewhat impaired groups were likely to need treatment services, representing 15.5% of the women on AFDC.

- The National Center on Addiction and Substance Abuse (CASA) at Columbia University used the 1991 National Household Survey on Drug Abuse to estimate that among women receiving AFDC age 18 to 44, 9.9% were regular users of alcohol only, 12.5% were users of drugs only, and 20% were regular users of alcohol and/or drugs. Regular use was defined as at least monthly use of drugs or four or more episodes of binge drinking (five or more drinks in one sitting) in the last month.[3]

- Researchers at the National Institute on Alcohol Abuse and Alcoholism used data from the 1992 National Longitudinal Alcohol Epidemiologic Survey to determine the number of respondents over age 18 who received AFDC (and other federal aid programs) in the previous month and those who reported heavy drinking, drug use, or met DSM- IV criteria of abuse or dependence. They found that among AFDC recipients, 13.2% were heavy drinkers, 7.6% met DSM IV criteria of alcohol abuse and/or dependence, 9.8% reported drug use in the previous year, and 3.6% met DSM IV criteria of drug abuse and/or dependence. The two primary conclusions drawn from this study were that: (1) a small percentage of AFDC recipients (and other clients of benefit programs) are heavy drinkers, use drugs, or abuse or are dependent on AOD; and (2) rates among welfare recipients were similar to rates of use, abuse, and dependence in the non-welfare population.[4]

- The Urban Institute's examination of the National Longitudinal Survey of Youth (NLSY), potential barriers to employment were classified as serious or moderate. Substance abuse was considered a serious barrier to employment. Their results are summarized in the table.

Responses about AOD Status	Percent of Current Welfare Recipients	Percent of Non-Recipients
Is concerned about being an alcoholic or has had recent problems at work or school because of drinking	4.88	4.84
Some physical indication of problem drinking (shakes, loss of memory, drinking in the morning)	19.98	9.46
Has used or currently uses cocaine or crack extensively (more than 100 times in one's lifetime)	8.70	7.29
Has used or currently uses marijuana extensively	15.67	14.54

However, studies that have been based on samples of clients seeking AFDC benefits, rather than on samples composed of the general population, have found percentages in the higher range. Highlights of these state-level studies follow:

- Screening for drug and alcohol problems among Maryland AFDC recipients found that 20.8% were alcohol and/or drug users and 16.1% met the threshold for alcohol and/or drug abuse that would indicate impairment.[5]

- In Iowa, in 1995, among long-term AFDC recipients, 24% were current AOD abusers and 32% were past AOD abusers. Although family members' AOD use would not necessarily impair an individual from participating in job training and should not be included in estimates of AFDC recipients' AOD use, it is important to note that 38% of grantees in Iowa were adult children of an alcoholic parent.[6]

- Among clients in the Chicago Commons West Humboldt Park Employment and Training Center, 30% self report current or past substance abuse problems.[7]

- In a rural Oregon JOBS program, two-thirds of participants reported using illegal drugs although only 13% self-reported having a substance abuse problem. However, 27% reported that other persons were concerned that they had a substance abuse problem[8] (this question is included in several AOD screening instruments).

- In Kansas, the state authorities have estimated that 20% to 50% of TANF clients are adversely affected by AOD and 20% of TANF women failed pre-employment drug tests.[9]

- AFDC caseworkers in Utah report AOD-related problems as a "risk factor"for clients participating in their Family Employment Program. Based on 46,262 clients evaluated from July to September 1996, workers reported differences with AOD problems among different age groups. These data are shown in the table on the following page.

Age Group:	<18	18 - 25	26 - 35	36 - 45	46 - 55	56 - 65	> 65
Percent with AOD Problem	1.8	36.0	39.2	19.2	3.5	0.4	0.0

To summarize, only the study by NIAAA used the narrower diagnostic criteria from the DSM-IV to determine the percentage of the AFDC population with substance abuse or dependence. They found that 7.6% met DSM IV criteria of alcohol abuse and/or dependence and 3.6% met DSM IV criteria of drug abuse and/or dependence. However state-level studies, using methods of detection similar to methods used in other states implementing welfare reform, generally find two and three times that rate among their clients. In light of the larger percentages found among state caseloads than in the federal estimates, states should be clear about the estimation method they elect to use and its impact on the results they will obtain.

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Appendix 3
Examples of Commonly Used Screening and Assessment Instruments

- **The CAGE** is a very brief method for detecting the possibility of alcohol abuse. The modified CAGE detects problems with other drugs.[1] Studies have found that using the CAGE in medical settings such as emergency departments to identify covert alcohol problems is a cost-effective way of identifying patients who need treatment/recovery before their alcohol use creates additional health care costs. Since the CAGE is in the public domain, there is no cost for its reproduction and use. The CAGE asks four questions about alcohol or other drug use: need to **C**ut down, **A**nnoyance created by criticism from loved ones or friends, **G**uilt feelings, and whether an **E**yeopener is ever needed; hence CAGE.

- **CSAT's Simple Screening Instrument for AOD Abuse**[2] was designed to encompass a broad spectrum of signs and symptoms for substance use disorders. The view of AOD abuse problems and disorders reflected in the screening instrument is consistent with that adopted by the World Health Organization and the American Psychiatric Association, based on the concept that AOD abuse disorders are biopsychosocial disorders and cause impairment and dysfunction in physical, emotional, and social domains.

- **The Substance Abuse Subtle Screening Inventory** (SASSI) is currently in use as a screening tool in General Relief (GR) eligibility centers in several counties in California. It is also used in the criminal justice system with court-ordered AOD programs, in correctional settings, and in several countries outside of the United States. Reliability testing of the SASSI has found a 90% to 92% rate of accuracy in identifying AOD dependence. The instrument also yields clinical information including the level of defensiveness, denial, and co-dependence. The SASSI meets the criteria for consideration as an acceptable screening tool based on considerations of cost, reliability, validity, usefulness, appropriateness, cultural sensitivity, bias and credibility. It is a proprietary tool with a nominal fee.[3]

- **The Structured Clinical Interview for Diagnosis** (SCID),[4] is a psychiatric interview form using the DSM-III-R diagnostic criteria to enable the interviewer to either rule out or to establish a diagnosis of "drug abuse" or "drug dependence" and /or "alcohol abuse" or "alcohol dependence." The DSM-III-R criteria for substance abuse diagnoses are the same for adolescents as for adults. The SCID can be used for adolescents and for adults. These diagnoses can be made by the examiner asking a series of approximately 10 questions of a client. The interview time for determining the presence of a substance abuse/dependence diagnosis with the SCID is approximately 10 minutes.

- A newly developed screening technique first used in Cambridge, Ontario, uses a series of indirect questions about accident history to identify persons with alcohol problems. Using this method, approximately 70% of the problem drinkers in a test population of 15,000 were identified and many were directed to treatment. The method has been introduced in the U.S. through a Philadelphia health provider and is being taught to a New York area HMO.[5]

Assessment Instruments for Treatment Planning and Outcomes Monitoring

Using a standardized assessment tool is imperative in order to collect follow-up data on clients to demonstrate treatment effectiveness as required by the TANF legislation and by managed care plans. Since AOD problems differ from one individual to another, it is crucial to document the differences in order to measure changes that can be attributed to treatment. A review of current practice shows a wide variation in the data considered for treatment/recovery planning and system monitoring and tracking. Programs use one or more of many assessment tools in addition to the DSM criteria and the Mental Status Examination. Among the most widely used assessment tools are the Addiction Severity Index (ASI), the Beck Depression Inventory (BDI), and the Minnesota Multiphasic Personality Inventory (MMPI); others are used as well.

Nevertheless, some form of standardized assessment information is necessary under a managed system of care to facilitate tracking of patient change and outcomes. Consideration of standardized assessment protocols should be based on the factors of cost, reliability, validity, usefulness, appropriateness, cultural sensitivity, bias, credibility, and comprehensiveness.

- The Addiction Severity Index (ASI),[6] developed by McLellan and colleagues in the 1980s, is widely considered to be the best-known of the standardized AOD assessment tools currently in use. The Addiction Severity Index (ASI) is a comprehensive, structured interview assessment tool used at treatment program intake, discharge, and follow-up. Computer technology has been developed for data input and analysis. The ASI measures the severity of potential problems in seven domains commonly affected by alcohol and drug dependence: alcohol use, drug use, legal problems, social and family problems, medical problems, employment problems, and psychological functioning. Its composite scores can then be used as measures of change in patient responses over time. The Treatment Research Institute in Philadelphia has developed a compact version of the ASI, known as "ASI Lite," which can be administered in 20-30 minutes.[7]

- The Individual Assessment Profile (IAP)[8] is a structured intake assessment interview developed by staff at the Research Triangle Institute. The IAP has been automated and can be administered with a computer-assisted format. It takes about 50 minutes. The IAP can be used to document treatment services provided and to assess changes in behavior after 3, 6, and 12 months of treatment. Data elements from both the ASI and the Federal Client Data System have been incorporated into the IAP in an effort to develop a standardized assessment that can be used across drug treatment programs.

Appendix 3 - Notes

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Appendix 4
Drug Testing

Biochemical methods to detect drug use are limited by several factors. The tests can generally only detect recent use and cannot measure frequency or patterns of use, or the route of consumption.[1] (A list of commonly used drugs and their detection periods follows.) There is no reliable evidence that a positive urine test correlates with impaired functioning or behavior. There is general agreement that laboratory screening methods are significantly less useful than questionnaires for identifying persons with alcohol problems. For alcohol, laboratory screens such as urinalysis have comparatively low levels of sensitivity, resulting in a large number of cases going undetected.[2] Biochemical testing tends to be more costly than questionnaires and requires specialized skills and a controlled environment for obtaining reliable samples.

Urine Testing. While urinalysis is the most commonly used drug test, it generally detects only very recent use (within 48 hours, except for marijuana). Conducting a urine test using established NIDA guidelines costs between $50 and $100 per test. Using one of the portable kits which changes the urine to a different color if substances are detected (similar to reagent strips), costs approximately $5 to $10 per test. However, this lower cost method would not meet legal standards should the results be questioned in court.

Hair Testing. Head hair as a means of detecting the most commonly used illicit drugs has been the subject of extensive and recent research. As hair is formed in the scalp it is nourished by the blood, and drugs present in the cells are deposited in the cells at the root level. Hair may also be exposed to drugs through normal sweat processes.[3] Researchers have found that the level of the drug taken is often correlated with the amount deposited in the hair cells. More important is that a historical record of a person's drug use level can be obtained, with hair and the root level showing recent use and hair further from the root showing evidence of use months before the root was formed—especially in people with long hair. Advantages of the test are that it cannot be easily falsified (although a shaved head or even short hair would forestall the analysis of the trend of use) and the technique of obtaining hair is noninvasive and less objectionable to some persons than that of obtaining urine. The drawbacks include the lag between use and response time which limits its ability to determine recent use, the possibility of environmental exposure rather than the individual's use,[4] and its cost (roughly $50 per drug tested). In addition, since more drug metabolites remain in dark hair than light hair, the method may be perceived to include racial bias.

Sweat Testing. The sweat patch is a relatively new method of drug testing that shows promising results. A recent study to detect cocaine use found that the patch accurately determined cocaine levels reflective of the levels used. While the data did not reveal either the dose or the time of use, it could be used to diagnose a single episode of cocaine use as far back as seven days, compared to a maximum of 48 hours reflected in a urine specimen.[5] Other research testing the patch's utility for detecting codeine and phenobarbital found similar results,[6] concluding that the tamper-proof sweat patch is a reliable, non-invasive means of estimating drug exposure over a wider period of time than urine screens. To date, the sweat patch has been used primarily in the criminal justice system. The patch is worn on the arm for one week. It can be removed with tweezers, but once removed it cannot be put back on. After removal it is mailed into a laboratory for analysis. The results reveal evidence of the actual drug used, rather than its metabolites, which eliminates false positives such as the "poppy seed effect" described below.

Blood Testing. Using blood specimens is generally done only when special circumstances exist, such as an auto accident or workplace incident. Clearly the most invasive of the specimen collection methods, it is also more expensive and unlikely to be used with the welfare population. Reagent strips test saliva and have

demonstrated an excellent correlation with blood alcohol levels.[7] In addition, blood alcohol level can be determined from breathalyzer tests but is limited to detection of alcohol consumed in the prior 24 hours.

Integrity of Drug Testing

To ensure the integrity and validity of the laboratory results, three interdependent and essential components of a urine drug test *must be* followed. The testing begins with specimen collection, proceeds to laboratory analysis, and then culminates in the interpretation of the reported results by a medical review officer.[8] The standardized laboratory process has been developed by the NIDA, and forensic toxicologists have refined it further.

It is extremely important that the urine to be tested is certified to have been obtained from the person being tested. Individuals being tested may attempt to alter urine specimens by adding substances or by dilution with water, rendering the urine unsuitable for analysis. Such efforts to avoid detection may be discovered by measuring the temperature, specific gravity, and pH of the urine; however, the general health status of the donor may also affect the values. Therefore, procedures must be in place to ensure that a specimen came from a particular donor, at a particular time and place, that the specimen is unadulterated, and has not been tampered with between collection and submission to the laboratory.

Such procedures are not trivial and require trained staff. Specimen collection must occur under direct or indirect observation. If directly observed, staff must be prepared to handle resistant donors. In the indirect collection process, the actual voiding of urine is not witnessed, but safeguards are taken to ensure specimen integrity. Such measures include ensuring no access to water taps, placing a bluing agent in the toilet bowl, and measuring the urine specimen temperature immediately after collection to detect any dilution or substitution. After either procedure, a tamper-proof seal is placed over the collection bottle for transportation by courier to the laboratory, generally preprinted with a unique identification number and dated and initialed by the donor after sealing. The specimen is accompanied to the laboratory by a completed chain-of-custody form.

It is possible that drug exposure did not result from the individual's conscious or intentional action. Two of the most commonly claimed sources of unintentional exposure are the passive inhalation of cannabinoids from marijuana smoke and the unintentional consumption of morphine and codeine from poppy seeds. Other false positives can result from the use of over-the-counter decongestants and legitimately prescribed drugs. NIDA currently recommends a confirmation level of 15 ng/ml, making it unlikely that the passive inhalation of marijuana smoke will result in a positive urine screen; however, because of the poppy seed effect, every urine reported to a medical review officer as containing morphine must be investigated to determine whether it resulted from intentional drug use.[9]

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COMMONLY ABUSED DRUGS AND THEIR DETECTION PERIODS[10]

Alcohol and other drugs can be detected in body fluids for different lengths of time. The time frames are based both on the type of drug and the type of body fluid tested. Below are some commonly abused substances and the amount of time after use during which they are detectable.

Drug Class and Common Names	Methods of Use	Detection Period
Stimulants Amphetamines - Biphetamine, Dexedrine	Injected, swallowed, smoked, or sniffed	1 - 2 days
Cocaine	Injected, smoked, or sniffed	1 - 4 days
Methamphetamine - Desoxyn, Street names: Speed, Ice, Crank	Injected, swallowed, smoked, or sniffed	1 - 2 days
Methylphenidate - Ritalin	Injected or swallowed	1 - 2 days
Nicotine is found in cigarettes, cigars, snuff, and other tobacco products including the nicotine patch	Smoked, or oral	1 - 2 days
Hallucinogens LSD	Swallowed	8 hours
Mescaline	Swallowed	2 - 3 days
Phencyclidine (PCP)	Injected, swallowed, smoked	2 - 8 days
Psilocybin (comes from mushrooms)	Swallowed	8 hours
MDMA - Ecstasy, DOB, DOM, MDA	Swallowed	1 - 2 days
Marijuana	Smoked or swallowed	1 day to 5 weeks
Hashish	Smoked or swallowed	1 day to 5 weeks
Tetrahydrocannabinol, the active ingredient in marijuana has been synthesized in the drug Marinol	Swallowed	1 day to 5 weeks
Anabolic steroids	Injected or swallowed	Oral: 3 weeks Injected: 3-9 months

Drug Class and Common Names	Methods of Use	Detection Period
Opiates and Morphine Derivatives Codeine	Injected or swallowed	1 - 2 days
Heroin	Injected, smoked, or sniffed	1 - 2 days
Methadone	Injected or swallowed	1 day - 1 week
Morphine	Injected, swallowed, or smoked	1 - 2 days
Opium	Swallowed if medical use	1 - 2 days
Depressants Alcohol	Swallowed	6 - 10 hours
Barbiturates	Swallowed or injected	2 - 10 days
Benzodiazepines	Swallowed or injected	1 - 6 weeks
Methaqualone (Quaaludes)	Swallowed	2 weeks

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Appendix 5
The American Society of Addiction Medicine (ASAM)
Patient Placement Criteria for the Treatment of Substance-related Disorders

The ASAM criteria are based on a client's level of functioning in six dimensions

1) Acute intoxication and/or withdrawal potential
2) Biomedical conditions and complications
3) Emotional/behavioral conditions and complications
4) Treatment acceptance/resistance
5) Relapse/continued use potential
6) Recovery environment.

Based on the assessment of the client on the six dimensions, the levels of care available for clients are:

Level 0.5 Early Intervention

Level I Outpatient Services

I-D Ambulatory Detoxification without Extended On-site Monitoring
I - Outpatient Treatment

Level II Intensive Outpatient/Partial Hospitalization Services

II-D Ambulatory Detoxification with Extended On-site Monitoring
II.1 Intensive Outpatient Treatment
II.5 Partial Hospitalization Treatment

Level III Residential/Inpatient Services

III.1 Clinically Managed, Low-Intensity Residential Treatment
(Halfway house; Supportive Living Environment)
III.2-D Clinically Managed Inpatient Detoxification Services
(Social Detoxification)
III.3 Clinically Managed, Medium-Intensity Residential Treatment
(Extended Residential Program)
III.5 Clinically Managed, Medium/High-Intensity Residential Treatment
(Therapeutic Community)
III.7-D Medically Monitored Inpatient Detoxification Services
III.7 Medically Monitored Intensive Inpatient Treatment

Level IV Medically Managed Intensive Inpatient Services

IV-D Medically Managed Inpatient Detoxification Services
IV Medically Managed Intensive Inpatient Treatment

Appendix 6
Factors Affecting Treatment Outcomes

Domain	Client Barriers to Success	Client Strengths and Assets
Age	Under age 30	Over age 30
Employment	Unemployed with little work history	Stable employment history
Motivation	Little acceptance of AOD problems	Desire to recover
Consequences and sanctions	Little fear of AOD-related consequences (e.g., loss of job or custody of children)	Fear of consequences reinforced by sanctions
Physical and social environment	Return to a neighborhood where drugs are readily available and with a drug-using peer group	Little contact with a "drug culture" and fewer life stressors (e.g., poverty)
Legal status and Peer criminality	Numerous pre-treatment arrests and a peer group involved with criminal acts	Few pre-treatment arrests and a non-criminally involved peer group
Social support	Family members or peers who cause interpersonal conflicts or fail to support goals of recovery	Family members and peers who exert pressure to stop substance use and provide emotional support for recovery
History of drug use	Using a variety of drugs, frequent drug use, younger age at onset of addiction, a longer course of addiction, and few days of sobriety prior to entering treatment	Use of a primary substance, older onset of addiction, a period of abstinence prior to treatment admission
History of treatment	Numerous treatment attempts	Longer length of time in-treatment
Dual diagnosis and Psychological problems	Significant psychiatric problems, high levels of anger, depression, childhood sexual abuse	No concurrent psychiatric disorders
Chronic illness	Significant chronic illnesses (e.g., arthritis, back pain, asthma, emphysema, ulcers)	Good physical health

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This guidebook was greatly improved by the valuable comments from each member of the review panel and the editing assistance of Brian Perrochet. However, the views expressed are those of the authors alone and do not reflect endorsement from the panel members or their organizations.

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The authors wish to acknowledge the contributions of the Children and Family Futures associates, particularly Merrill Powers for her dedication and efforts on this project, Irene Skricki of the Annie E. Casey Foundation who served as project officer, and numerous colleagues who offered suggestions and provided their input, particularly those who served on the review panel.

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